

MEDICAL LEGISLATIVE INITIATIVES

HEARING BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES ONE HUNDREDTH CONGRESS

SECOND SESSION

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MEDICAL LEGISLATIVE INITIATIVES

WEDNESDAY, MAY 4, 1988

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. G. V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Penny, Staggers, Rowland of Georgia, Stenholm, Harris, Kennedy, Hammerschmidt, Stump, Smith of New Jersey, Bilirakis, and Rowland of Connecticut.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. MONTGOMERY. The subcommittee will come to order.

Good morning. The purpose of this hearing is to receive testimony on some draft legislative initiatives having to do in large part with problems of recruiting and retaining health care professionals, especially in the nursing field. Included are draft provisions which would:

Authorize premium pay for LPN's and nurse assistants;

Authorize flexible rates of pay for nurses hired on an intermittent basis;

Waive parking fees for hard to recruit and retain health personnel;

Exclude from VA ceilings personnel who are paid for by DOD under VA/DOD sharing; and

Clarify that "hybrid" title 38/title 5 personnel are not prohibited from "moonlighting" jobs.

In addition, we will receive testimony concerning two proposed extensions. First is an extension of the alcohol and drug abuse halfway house program, and second is a proposed extension of the grant program with a one-year increase in the amount of the grant for the Veterans' Memorial Medical Center in the Philippines.

The Administrator called me about the alternative of raising the fee to the medical center in the Philippines.

We will receive testimony on a provision that would require the VA to abandon new regulations that permit on a 45-day extension to the authority for non-service-connected, six-month, community-based nursing home care. The VA would be required to return to the previous regulations which allow medical judgment to determine extensions beyond the six-month limit.

Last, there is a draft provision that would transfer title of certain medical equipment from the VA to chapter 82 State medical

schools. This equipment was acquired under title 38 authority to assist in establishing new State medical schools.

I want to thank our witnesses for being here today.

Also, if I might have the attention of the staff and members, today is a special occasion. It is my pleasure to ask you to join with me to wish John Paul Hammerschmidt a happy birthday. We really don't know what his age is, but he has to be young. He still does not wear glasses.

Happy birthday, John.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. I thought you were going to say the reason we called this meeting was because it was my birthday.

However, if you won't tell how many birthdays we have celebrated since we were freshmen together, I won't tell either, Mr. Chairman.

Mr. MONTGOMERY. Okay.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Now that our business carried over for the first session of this Congress is essentially completed, we are able to look toward additional health care needs of veterans and the ongoing legislative requirements of the VA's Department of Medicine and Surgery.

By the way, Sonny, it is to your great credit that you had the steady patience and firm resolve necessary to achieve the outstanding conference results obtained in the numerous provisions on outpatient and domiciliary care eligibility, beneficiary travel benefits, compensation for radiation exposure, as well as a host of other important provisions.

However, it is well known that you are not one to rest on your laurels, and I commend you for your continuing initiatives which this hearing will examine and, no doubt, advance.

You know, the recruitment and retention of highly qualified health care professionals may be the toughest immediate problem facing the VA's health care system, although there is certainly no shortage of rough problems with the austere budgeting situation facing the VA. Innovation and flexibility will be necessary for the VA to successfully compete in the market for the health care professionals essential for staffing VA hospitals and clinics, particularly with nurses, as you have noted, Mr. Chairman.

With the drug epidemic, for good reason, showing up in many opinion polls as a major concern of Americans, it would be unthinkable to cut back in the battle against alcohol abuse which is by far the most common drug problem. Extension of the alcohol and drug abuse halfway house program is under consideration, and, if the program is found to be effective, certainly its authorization should be continued.

Finally, Mr. Chairman, if VA health care personnel retention and recruitment is an immediate problem, perhaps the toughest long-term problems in the VA health care field are to be found in the enormous challenge posed by the growing number of older veterans.

An aspect of this is authority for extensions of community-based nursing home care. The VA appears to have taken a step backwards with a limit of 45-day extensions for many cases, and I want to learn the VA's justification for it. Many of my constituents ask for help with these extensions, and I am very aware of their needs in this area.

Mr. Chairman, our subcommittee's work for the remainder of this Congress is before us, and I look forward to hearing the testimony of our witnesses.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, John Paul, and happy birthday again.

We will ask our first panel to come forward. We do have two panels today. We would like to move this hearing along, as we will be going into session in the near future.

Dr. Gronvall, as the witnesses accompanying you come to the table, let me mention that Mack Fleming and I went out to Kirtland Air Force Base which is in Albuquerque, New Mexico. We went for two reasons: one to talk about the GI bill to a graduating educational group in the Air Force at Kirtland, and we visited the new VA hospital at Kirtland.

They said you hadn't been out there. I am requesting that you go out there and look at that sharing agreement between the Veterans' hospital and the U.S. Air Force. It is working wonderfully well.

Two things are coming out of it. We are getting better medicine to the veterans, and we are getting better medicine to the Air Force. They have 28 sharing agreements between the Air Force and the Veterans' Administration.

Secondly, it is saving the taxpayers a lot of money. We have combined a hospital that we built with the Air Force so they didn't have to build an additional hospital at Kirtland Air Force Base.

It is really working wonderfully well, Dr. Gronvall, and I certainly hope you will go out there. The powers that be in the Air Force or the medical professionals of the Defense Department have not been out there either.

This is the way we are going to have to go in years to come with the cost of medical care as it is, and I certainly hope you will get out there as soon as possible. It is a good team out there. You have the director and the person who is handling the sharing agreements for the VA—they are good men, and I want to congratulate you. That is a good project.

The reason it is working is because they wanted it to work, and they are making it work.

Dr. GRONVALL. Mr. Chairman, let me make a quick comment on that.

I very much appreciate your high praise and compliment for the sharing arrangement that we have worked out there with the Air Force. I have been kept regularly informed of the progress, and it truly is a show piece.

Recently, there was an article published in one of the professional journals written by both the Air Force and the VA people describing the whole basis of planning and the collaborative working relationship that was developed there.

I had earlier been scheduled to go out there for the dedication and then had a conflict that I couldn't change. However, in fact, I have looked at my calendar and am going to be in the Southwest during the first week in June and plan to stop by.

I will also talk to Dr. Murph Chesney, the Surgeon General of the Air Force and look for a time when he and I might be able to visit.

I couldn't agree more that it is a remarkable collaborative agreement there that benefits both the Air Force and the Veterans' Administration and the patients that we both serve. So, it truly is a model, and I appreciate your comments.

Mr. MONTGOMERY. The Air Force has followed up on this sharing agreement, and the other services really haven't done that much. I hope we could get some of those Surgeon Generals out there also.

I will give an example to my colleagues of how well this is working out there. In the veterans' hospital, as far as emergency care, quick care—and some of our veterans' hospitals, am I not correct, these veterans would go to other hospitals to get quick emergency care. Our VA hospitals don't offer that life surviving service. Is that correct?

Dr. GRONVALL. Actually, most do, but some, particularly our smaller hospitals do not, so we would have to make such arrangement also.

Mr. MONTGOMERY. So, in that case, I think that hospital does not, but the Air Force needs that emergency care. So, now veterans can go directly and get the emergency care and don't have to go to a hospital in Albuquerque.

And we saw a VA doctor there working with an Air Force medical doctor, working right together on an emergency patient.

The other matter is that the Air Force hospital out there did not have the means to do hip and knee surgery, but the VA did have those facilities because of their connections with the university hospital. To do an Air Force knee replacement cost between \$30,00 and \$40,000 downtown. Now, since we have the combination of the hospitals there and the sharing agreement, the VA does the knee operations for the Air Force, and it costs \$2,000.

So, that is an example of having greatly saved the taxpayers money and give you a good service, too, Dr. Gronvall.

Dr. GRONVALL. Good. Thank you very much.

STATEMENT OF JOHN A. GRONVALL, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ACCOMPANIED BY GEORGE KVASNICKA, ASSOCIATE DIRECTOR FOR PERSONNEL POLICY; AUDLEY HENDRICKS, OFFICE OF GENERAL COUNSEL; AND DON JOHNSON, OFFICE OF FACILITIES

Dr. GRONVALL. Mr. Chairman, you have already called attention to the fact that two other witnesses are with me here. On my left is Mr. Audley Hendricks from our General Counsel's office. On my right is Mr. George Kvasnicka who is from the Office of Personnel and Labor Relations.

We have also here at the table Mr. Albert Bland from the American Ex-Prisoners of War, although I believe his testimony will come after you have asked questions of the VA witnesses.

We have submitted a detailed statement that covers each of the topics on the legislative agenda today, and I would request that the statement be included in the record.

Mr. MONTGOMERY. Without objection, so ordered. Your full statement will be entered into the record.

Dr. GRONVALL. Thank you.

Then, in the interest of time, I can just make a few brief introductory comments.

First, we very much appreciate the legislation that would extend our authority for the community contract halfway house program for veterans suffering from alcohol, drug dependency, and drug abuse problems. We have seen that the program is cost effective. It functions well, and we in fact would recommend that the authority for that program be made on a permanent basis.

Second, we fully support the extension of our authority to make grants to the Veterans' Memorial Medical Center in the Philippines. As you noted in your opening comments, the Administrator of the Veterans' Administration, General Turnage, recently visited the Philippines. I know, Mr. Chairman, that you yourself recently also visited the Philippines.

Mr. Turnage personally visited the medical center and has discussed with me the great needs of the program there. So, we support continuing that grant support program.

Third, we do favor and support the proposal to transfer equipment from the Veterans' Administration to the new State medical schools that were established by special legislation. The equipment purchased for those schools is now from 8 to 14 years old, is really of little continuing value to the VA, and we believe the most efficient way to handle the equipment is to transfer title to those medical schools.

Next, we support the proposal that would allow the VA to appoint retired military nurses without a requirement that we reduce the individual's retirement pay. We have contacted the Department of Defense on this matter, and they want some time to review the situation and present their views.

So, we are requesting that the committee defer taking action at this immediate time, but we do clearly support that proposal.

Next, we do agree in concept with the proposal to provide additional flexibility in setting pay rates for intermittent nurses. We do, however, believe that we have existing authority to achieve that purpose, and we plan to actively explore more extensive use of that authority.

We have reviewed the proposal to remove the FTEE control in the instance of VA and DOD sharing agreements. Once again, in regard to that proposal, we would like some time to confer with the Department of Defense to see the extent to which we do have a problem with the FTEE ceiling controls, and we would like to work further with the Department of Defense and the committee to accomplish a system of accounting for the FTEE in such a way that it doesn't create a disincentive to sharing agreements.

Finally, in the full text of our statement, we do give reasons why a number of the specific legislative proposals do not have the support of the Administration. The statement is self-explanatory in that regard.

With that, Mr. Chairman, my colleagues and I here at the table as well as other VA staff who are in the room would be pleased to respond to specific questions from the committee.

[The prepared statement of Dr. Gronvall appears on p. 33.]

Mr. MONTGOMERY. Mr. Hammerschmidt?

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Dr. Gronvall, the VA would prefer that the contract program for alcohol and drug abuse treatment be made permanent. Is that correct?

Dr. GRONVALL. Yes, sir.

Mr. HAMMERSCHMIDT. Does OMB concur with that?

Dr. GRONVALL. Yes, sir, and in fact, we have submitted a legislative proposal making such a recommendation, so we have had the concurrence of OMB.

Mr. HAMMERSCHMIDT. Regarding the VA's regulations on extensions of 45 days beyond 6 months for community home nursing care, is the VA planning to collect information on how often the extensions are requested, how often they are granted, and so forth?

Dr. GRONVALL. Yes, we surely will be doing that. The regulation, as you know, was just recently published, so it is too early to tell what the impact of that would be, but a part of our routine monitoring will be to collect such information.

Mr. MONTGOMERY. Would the gentleman yield at that point?

Mr. HAMMERSCHMIDT. Yes, I yield.

Mr. MONTGOMERY. For clarification for myself and other members, we have a person in a VA nursing home. Give us the steps that you take in that. I know that comes up with a number of Members. Once you get them in there, the families, I understand, don't want you to move them out, but then you have some policy that you move them to private nursing homes.

How does that work, and how does that affect what John Paul just asked you?

Dr. GRONVALL. I would be pleased to make a comment, Mr. Chairman, and then I do have other staff here, particularly Mr. Jim Kelley from our Office of Geriatrics and Extended Care who could expand on it.

Basically, the current authority that we have for nursing home care of non-service-connected veterans—and the whole issue, I think, focuses on non-service-connected veterans—we clearly understand limits our authority to provide nursing home care in community contract nursing homes for a period of six months in the ordinary circumstance.

When a non-service-connected veteran is in one of our hospitals, it is in fact our requirement that the transfer to a nursing home involve the development of a plan such that the veteran's continuing care, if it is going to be needed beyond the six-month period, will be arranged for well in advance. In the vast majority of instances, we are able to make such arrangements.

We have recently proposed the additional regulation on the 45-day extension because there are some individual cases where the six-month period is utilized and a satisfactory alternative plan has not been possible. So, the regulation allows the individual medical center to provide support for an additional 45 days during which

arrangements are made for alternative care for the non-service-connected veteran.

I think, beyond that, our usual experience is for individual cases where, for whatever reason, some unanticipated problem occurs and an alternative plan could not be accomplished within that period, we do have some other alternatives. For example, the veteran could be readmitted to one of our hospitals again as a way to continue the care while we continue to work to look for an alternative treatment arrangement.

Mr. HAMMERSCHMIDT. That was going to be a follow-up question. I was going to ask you what happens after the 45 days if you didn't have any other plan, but evidently you are trying to find ways to take care of veterans without putting them out on the street after 45 days.

Dr. GRONVALL. Yes, and we surely always encourage our medical center directors and our chiefs of staff that in the individual instance of an individual veteran where all the rules and regulations would require that the VA no longer provide care, if, in fact, there really is no alternative, we will find some way to continue the care, for example, by readmission to the hospital which may be the easiest way to handle that, and we would in no case put someone out on the street where there was not an alternative worked out.

Mr. HAMMERSCHMIDT. Dr. Gronvall, it just seems like because of bureaucratic regulations, it wouldn't really make sense to readmit a veteran to a hospital when he doesn't need the care if what he really needs is long-term care. Maybe we can speak to that legislatively. You may have no other alternative under the authority, but—

Dr. GRONVALL. Under our interpretation of the existing statutes, I believe we don't have another alternative.

Mr. HAMMERSCHMIDT. Maybe we need to take a look at that to give you more flexibility in that area.

Dr. GRONVALL. Again, this all derives from, I think, the statute that, to our understanding, establishes the six-month period of eligibility in the case of a non-service-connected veteran.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Harley Staggers was here and had to leave. Dr. Rowland?

Dr. ROWLAND of Georgia. Thank you, Mr. Chairman.

Mr. Staggers did leave a question that he wanted me to ask, and I will ask it for him. This is in reference to Winchester, Virginia.

He says that the VA is closing a halfway house there, I believe, and transferring funds to another function. He wanted to know whether or not it was believed by the Veterans' Administration that the halfway house was not needed now and what will take its place.

Dr. GRONVALL. I am unaware of the details of that specific instance, but I would certainly be glad to look into it, and we can supply a report back to you for the record on that particular case.

As a generalization, as our statement makes clear, the halfway house program has been highly successful. Individual instances I can't speak to, because we do have a considerable number of contract arrangements for halfway houses. Normally, some new ones

are being added and others dropped as the program rolls along, but I would be glad to look into that specific instance.

Dr. ROWLAND of Georgia. Please do, and supply the answer for Mr. Staggers, too. I am sure he would appreciate that.

Dr. GRONVALL. I surely will.

[Subsequently, the Veterans' Administration furnished the following information:]

Information available indicates that the halfway house in question is CALFC in Winchester, Virginia. This halfway house has a contract with the Martinsburg VAMC for the provision of contract halfway house care to patients with alcohol and substance abuse disorders. A request has been sent to Martinsburg VAMC for detailed information on this matter. We anticipate a prompt response from the station and will inform the chairman of the committee and Congressman Staggers of our findings as soon as they become available.

Dr. ROWLAND of Georgia. Dr. Gronvall, as you know, I am really concerned about the quality of care, medical care, particularly, in the Veterans' Administration. That is an area that I have really focused a lot of attention on.

One of the things that we have been hearing is that RN's in the VA say that they need more support in terms of assistants to them and ward clerks. Can you tell me what the experience of the VA is nationwide concerning assistant personnel for nurses?

Dr. GRONVALL. Yes. I think I would have to agree as a generalization that if you look at our total system, it would be desirable to have a larger number of support personnel to provide administrative support and management support which then frees the nursing staff and the physician staff to do the things that they alone can do in direct care of patients.

We do operate, of course, under a statutory mandate that defines the total number of personnel supported by our appropriation. Further, in the past couple of years, the Appropriation Act has set very specific ceilings on the number of administrative and support personnel that we are able to employ.

A year ago when one of those ceilings was first imposed, we found that, in fact, we were over that. So, in spite of the comment that I made, we had to reduce the number of aggregate administrative support personnel that we had working in our medical centers as a result of the mandate of the Appropriations Act.

So, I agree with your general observation. What we have done is take the total appropriation support that defines our total staff, and we have, of course, had to establish management control to live within the floors and ceilings that are imposed through it but within that, then, to make the best deployment of the various kinds of staff that we could within our medical centers.

Dr. ROWLAND of Georgia. We have been told by field personnel that premium pay is not possible for licensed practical nurses and nurse assistants. However, as you noted, Public Law 98-160 brought LPN's into title 38 for pay purposes.

What is your current guidance to the field regarding these two nursing categories insofar as premium pay is concerned?

Dr. GRONVALL. We do have special pay agreements for licensed practical nurses in a considerable number of our medical centers. I don't have the number right at my fingertips. We have, all in all, well over 500 agreements for special pay in a number of health oc-

cupations, registered nurses being, I think, the most frequent occupation for which we have special pay agreements. We do have authority to enter into special pay agreements for licensed practical nurses and have done so at a considerable number of our medical centers.

I would be glad to supply for the record the specific number of special pay agreements that we have for each of the several occupations.

[Subsequently, the Veterans' Administration furnished the following information:]

**Number of VA DM&S Facilities With Special Salary Rate Authorization for Basic Pay By
Occupation As of March 1, 1988 ¹**

[Under 38 U.S.C. § 4107 Authority]

Series	Occupations	No. Facilities
083.....	Police Officer.....	31
601.....	Blind Rehabilitation Specialist.....	1
601.....	Nuclear Medicine Technologist.....	51
601.....	Registered Respiratory Therapist.....	13
605.....	Nurse Anesthetist.....	19
610.....	Registered Nurse.....	111
610.....	Registered Nurse—ICU.....	5
620.....	Licensed Practical/Vocational Nurse.....	54
630.....	Dietitian.....	3
631.....	Occupational Therapist.....	20
633.....	Physical Therapist.....	76
642.....	Nuclear Medicine Technician.....	4
644.....	Medical Technologist.....	10
646.....	Histopathology Technician.....	5
647.....	Diagnostic Radiologic Technician.....	32
648.....	Therapeutic Radiologic Technician.....	13
649.....	Cardiac Catheterization Technician.....	1
649.....	Electroencephalograph Technician.....	1
649.....	Heart-Lung Machine Technician.....	8
649.....	Hemodialysis Technician.....	2
649.....	Inhalation Therapy Technician.....	1
649.....	Medical Machine Technician.....	1
651.....	Respiratory Therapist.....	3
660.....	Pharmacist.....	107
661.....	Pharmacy Technician.....	7
669.....	Medical Record Librarian.....	4
675.....	Medical Record Technician.....	6
679.....	Medical Clerk.....	1
681.....	Dental Assistant.....	4
682.....	Dental Hygienist.....	16
699.....	Certified Respiratory Therapy Technician.....	14
699.....	Ultrasound Technician.....	6
699.....	Health Technician (Perfusionist).....	1

¹ Total Authorizations—585.

Dr. ROWLAND of Georgia. Personnel is really a problem, getting adequate personnel. That is my understanding, and, of course, pay is one of the things that makes it difficult to get adequate personnel. I have heard from at least one VA about the crunch that they are really in in trying to maintain adequate personnel. While they might have enough facilities funds, they are really having a problem about personnel.

In fact, I understand that some hospitals have borrowed against maintenance and repair funds in order to try to recruit medical

staff. It seems to me that is really getting into a very difficult area there..

What plans are being made to try to aid with this problem in general? How are we going to deal with that? I am really concerned about the personnel count.

Dr. GRONVALL. Dr. Rowland, I share your concern. In a sense, the last thing I want to do is heighten your concern, but I feel an obligation to make a general comment to the fact that I believe every projection that I am aware of on the national scene indicates that for the next several years, at least, the crunch that we are experiencing in personnel is going to get worse rather than better.

I have had the opportunity to be a participant in a number of deliberations at the national level involving the American Hospital Association where I have been on the board of trustees and the various national nurses organizations that represent the profession as well as nursing education.

Unfortunately, the enrollment of nursing students is declining. A significant number of nursing schools have, in fact, closed during recent years. At this time, the demand for nurses in the hospital system of the country continues to increase.

So, we face a declining supply and an increasing demand. That has led, then, to what I think could actually be described as a kind of frantic cycle of individual hospitals increasing their pay levels as they try to recruit in a very tight market and retain the staff that they have.

That has led us, of course, to take many steps. The cornerstone of our response has been the special pay agreements. We are now at an annualized amount of some \$95 million in special pay agreements in order to try to retain health care professional staff.

As I look at the aggregate data of our total nursing staff defined as registered nurses and then as licensed practical nurses, I think we have done quite well on a national basis in protecting our total numbers. The problem is geographic. Particularly, our medical centers in large cities are having a great deal of difficulty because the market is much tighter on the East Coast and the West Coast and the Southeast in the large cities.

We have many other plans underway, a number of which are the subject of legislative initiatives being discussed today. Since it appears that the national problem is not going to be solved in the next year or two, I think we have taken the approach that our job in the Veterans' Administration is to do everything we can to recruit and retain our own staff. If that makes somebody else's problem worse, that is unfortunate, but our responsibility is to the veterans that we care for.

So, we are doing all of the things that are described in our statement and in other testimony we have made recently to try to protect our staff. But, again, I do share your concern, and I think it is a highly valid one.

Dr. ROWLAND of Georgia. Thank you, Dr. Gronvall.

My time is up, Mr. Chairman, but I would like to come back to this after you have gone around.

Mr. MONTGOMERY. All right.

Bob Stump of Arizona.

Mr. STUMP. Thank you, Mr. Chairman.

Dr. Gronvall, regarding the equipment you were talking about transferring, what kind of equipment is it and how much would the cost be? I assume there is going to be a saving by the transfer. How much would that be?

Dr. GRONVALL. The equipment that I am referring to was purchased by the Federal Government as a part of the special legislation that stimulated the creation of the five new State medical schools. As a part of that program, we had the authority to buy equipment that was needed by the medical schools for the medical education programs.

So, all of the equipment that we are referring to was in fact purchased by the Federal Government, but then installed, basically, in the medical schools and has continuously been used by the medical schools.

We have maintained records of all the equipment. The total amount of equipment that I am referring to I think adds up to something like \$9 million. The equipment is now old, much of it obsolete, in fact, not being utilized as a result of that.

A reasonable estimate of the current value of all of that equipment would be something on the order of \$200,000. So, the equipment is down to the point where it is virtually all obsolete and out of date.

It is our belief that just transferring title to the medical schools will be an effective, simple, and appropriate way to deal with the ultimate disposal of the equipment rather than having to follow the much more complicated GSA rules for transfer of title back to GSA and following Federal excessing procedures.

Mr. STUMP. You will have a saving by not having to go through all that?

Dr. GRONVALL. Yes, we believe that there will be.

Mr. STUMP. Thank you.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Bob.

I believe Mr. Stenholm and Mr. Kennedy both had to leave.

Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Good morning, Doctor and gentlemen.

What is the average pay of VA nurses?

Dr. GRONVALL. Ms. Ferguson is here, Vernice Ferguson. Can you answer that or Mr. Kvasnicka, can you answer?

Mr. KVASNICKA. The latest figure I have is about \$32,000.

Mr. BILIRAKIS. I am certainly far from an expert, but that seems to be higher than the average pay of nurses in the private sector, isn't it? I think so. That is my impression.

Mr. KVASNICKA. I don't have the figures on the private sector. That does reflect our full range of nurses, the—

Mr. BILIRAKIS. Yes, it is an average, right.

Mr. KVASNICKA. Yes.

Mr. BILIRAKIS. What is the starting pay, generally, would we say?

Mr. KVASNICKA. In the twenties.

Mr. BILIRAKIS.

Dr. GRONVALL. And I think that is pretty well consistent with the private sector.

Mr. KVASNICKA. Under our special rate program, we try to "be competitive" within the range of the locale of the hospital.

Mr. BILIRAKIS. There is something else I have always kind of wondered about, the medical doctors who are part of the VA system. Do they carry malpractice insurance?

Dr. GRONVALL. No, sir. Our physicians are protected under the Federal Tort Claims Act, so they do not have to carry individual policies.

Mr. BILIRAKIS. I appreciate that, but I just wondered whether any of them feel that they have to anyhow for additional protection, if you will, or maybe lack of confidence. But you are finding that really none of them are having to carry their own malpractice?

Dr. GRONVALL. A significant number of the physicians that work in our hospitals are on part-time appointments with the Veterans' Administration and they then practice in a university hospital or a community hospital the rest of their time. Those individuals do carry malpractice policies.

However, by and large, I think the physicians working in the VA have been quite confident that the Federal protection applies to them.

Mr. BILIRAKIS. What kind of history are we running into, Doctor, regarding malpractice claims against VA doctors?

Dr. GRONVALL. Well, we try to track that quite closely. Again, I don't have the figures at my fingertips. The number of malpractice claims that we experience in the VA is significantly lower than the number experienced in a community hospital or university hospital based on the number of patients treated.

The data available from the private sector are not totally comprehensive, but we have collected information from a number of the major insurance companies that write private malpractice insurance. As best we can estimate our experience runs about 50 percent or 60 percent of the malpractice rate that is experienced in the private sector.

[See Malpractice Tort Claims on p. 48.]

Mr. BILIRAKIS. Thank you. I just have one final quick observation, Mr. Chairman.

Some time ago, we here in the House, at least, passed the Claims Act giving the Japanese reparations, the \$20,000. I voted against it, I am very proud to say, but I think the veterans around the country are just now becoming aware of it, because I am seeing—and I am sure the rest of us all are—an awful lot of letters to the editor from veterans protesting that.

I guess the point that I am trying to make is in the past—and, frankly, I compliment you, sir, and the system. We get many more compliments of the VA medical care than we do the other way around, but when we have gotten the other way, one of the things we have tried to say is lack of funding. How in the world are we going to be able to go back to these people at this point in time now that they are aware of what we have done in that regard and say lack of funding for America's veterans. That has resulted in quite a problem.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you. The gentleman makes an excellent point there, and before recognizing Claude Harris of Alabama, let me make two comments.

We notice that the Budget Committee turned down our request for additional bonuses for nurses. That brings up a point that was mentioned by you, Dr. Rowland.

Dr. Gronvall, I think you grabbed this thing a little hard on nurse shortage, because I am not sure that in the military bill that we don't have some bonuses and some pluses to attract nurses. So, that is going to make the competition harder for you to attract nurses into the VA system.

You might not be having problems in some areas of the country, but I know you are in larger areas. The professional nurses tell me that the benefits in the VA in the long run are better than the private community. Maybe the salaries are not, but the long-term benefits are much better.

Dr. GRONVALL. I appreciate the comment, Mr. Chairman. I agree with you, and we have tried to add and expand a number of benefits.

I think one of the ones that has been most successful has been the tuition support program. We initiated that a year ago and have significantly expanded it this year. I have received very enthusiastic reports back from our medical centers that our nursing staff see those kinds of additional educational benefits and support that we make available as being very attractive in helping to encourage them to stay working in the VA.

Mr. MONTGOMERY. Before you got here, Mr. Bilirakis, one thing I talked about was the sharing agreement, and how well it is working. If we ever get the VA hospital care that we need in Florida, you are going to have to come out with some type of sharing agreement with those military hospitals in Florida.

So, I would recommend that you and other members of the committee—not only do we need people from Washington, but we need people on this committee to go out there and look at that. Certainly, I would hope that you would go out there.

Mr. BILIRAKIS. Yes, sir, and I expect our forthcoming witnesses will also address that particular situation on behalf of their organizations, will they not?

Mr. MONTGOMERY. I doubt if they would right now, Mike, because the hearing was on nurses and nursing homes and so forth.

Mr. BILIRAKIS. Thank you.

Mr. MONTGOMERY. Claude Harris of Alabama.

Mr. HARRIS. Thank you, Mr. Chairman.

I feel like I am reporting from the last outpost over here. That is the reason you miss me.

Mr. MONTGOMERY. It is the way you voted yesterday, but we will forgive.

Mr. HARRIS. Okay, I voted right on what my friend from Florida brought up, Mr. Bilirakis. I voted with him on that.

Dr. Gronvall, in talking about the shortage of personnel and the crunch in the future, it would appear to me that a chief recruitment and retention tool as an incentive would be free parking. This would be especially true in some of our inner city hospitals

where there may be a higher instance of crime, and that would be a disincentive for employment at that particular hospital.

I would like to have your thoughts, comments and views, on the idea of a parking fee waiver as a recruitment tool.

Dr. GRONVALL. Mr. Harris, I would be pleased to comment on that.

Parking, certainly, is one of the most visible and highly symbolic benefits that exists in organizations. More blood and tears are spent over parking, I think, than almost any other single subject.

As you are aware, the Congress enacted specific legislation that mandates that we begin charging for parking at particular medical centers where we have built parking garages or have lease arrangements that fall above a certain dollar value. In order to implement that legislative mandate, we have published regulations, and our Chicago Lakeside Hospital will be the first one later this year to begin actually charging employees.

So, we don't have experience to speak from other than, I think, the general experience of all organizations that parking is a highly desirable benefit.

I would have to say, looking ahead, that the implementation of pay parking will have a negative impact on the staff working at the VA, and all of our evidence suggests that the impact will be significantly negative.

In today's legislative proposal, there is a specific legislative initiative which would waive the parking fee only for a few individual categories of personnel. We have opposed that in our statement mostly for the reason that we think it would become a highly negative factor to morale to have a special legislative definition of which employees do have to pay for parking and which don't have to pay for parking and that that creates a kind of invidious comparison and drives a wedge between the nursing staff and the support staff.

Dr. Rowland earlier was asking about support staff, and I think we fear that a specific proposal of that sort that makes such an invidious comparison would have an overall negative impact.

So, in summary, I think pay parking, in and of itself, will have a negative impact on the VA. Within that, we have tried to develop our regulations in such a way that we can implement the program in the fairest way possible and make it applicable to everyone who has to pay.

I have no doubt that it will complicate our special pay agreements and that we will be having to include in our special pay calculation the equivalent of the cost of parking to our employees where we have to enter into special pay to recruit and retain staff.

Mr. HARRIS. Of course, I was not here when they passed that law, I will be quick to add.

As I understand it, it was only where funds from the revolving fund would be used to construct or alter a garage at a cost of more than \$0.5 million or, in the case of acquisition by lease, more than \$100,000 per year. So, that would not be in all cases, then, would it?

Dr. GRONVALL. That is correct. We will be charging for parking only at individual medical centers where we have either built a parking garage or where we have a lease arrangement above that

dollar value. The rationale for that is that when we build a new parking garage, we have made the parking situation better by providing additional parking. Therefore, a charge is valid in the context of an expanded availability of parking places.

Dr. ROWLAND of Georgia. If the gentleman will yield, I would like to ask a question on that.

Mr. HARRIS. Certainly.

Dr. ROWLAND of Georgia. You mentioned Lakeside in Chicago, and I believe you are going to start charging there.

Dr. GRONVALL. Yes, sir.

Dr. ROWLAND of Georgia. Is that a new facility, the parking facility there?

Dr. GRONVALL. No, that is one where we lease a number of parking spaces in an existing garage that is owned by, I believe, the university.

Dr. ROWLAND of Georgia. I see. So, under the law, you would be required to start charging? Of would you not be required? That is the point that I am fuzzy on.

Dr. GRONVALL. Yes, we will be required to start charging.

Mr. JOHNSON is here from our Office of Facilities. Mr. Johnson, can you clarify the answer to the question? This is Mr. Don Johnson from the Office of Facilities.

Mr. JOHNSON. The way the law is written is that any garage that is leased at a cost in excess of \$100,000 annually will require the establishment of parking charges for all parking facilities at the particular medical facility. So, in the case of Chicago Lakeside which only has about 18 or 20 of its own spaces, the 200-space parking garage which is under lease at a cost of \$216,000 a year will require the establishment of parking charges. Under our regulations, those charges will be based on one-half of the comparable commercial parking rate in the area.

Dr. ROWLAND of Georgia. Does that money come from the revolving fund for that lease?

Mr. JOHNSON. Yes. All lease costs for parking garages come from the revolving fund no matter what the cost of that lease.

Dr. ROWLAND of Georgia. I see. I thank the gentleman for yielding, and I apologize for taking so much time.

Mr. HARRIS. Do I understand, then, that you charge a fee for all the parking spaces whether they are in that particular garage or not?

Mr. JOHNSON. That is right, sir.

Dr. GRONVALL. Once again, I think the rationale for that is that when, for example, a garage is added at a medical center, everyone who parks at the medical center benefits from that, because the availability of the garage frees up additional spaces in flat lots or pre-existing lots. So, it provides in that sense a benefit to all the employees. So, a parking charge for all parking is rationalized that way.

Mr. HARRIS. And how many spots were in the leased garage? You told him and I didn't hear the amount.

Mr. JOHNSON. It is over 200 spaces in the garage leased at Chicago Lakeside.

Mr. HARRIS. And how many would you have in all at the hospital?

Mr. JOHNSON. There are only about 18 or 20 in existence at the hospital. So, it would be about 218 or 220.

Mr. HARRIS. Mr. Chairman, that is all the time I have.

Mr. MONTGOMERY. Some of his time was taken. Did the gentleman want to ask a question about Birmingham?

Mr. HARRIS. Well, I will get together with Dr. Gronvall later about that.

Mr. MONTGOMERY. Okay.

Mr. HARRIS. We are still interested in that PET for the joint project between the U.A.B. and VA medical centers in Birmingham.

Dr. GRONVALL. Thank you, and I will be glad to discuss that with you and look into it.

Mr. MONTGOMERY. Chris Smith of New Jersey.

Mr. SMITH of New Jersey. Thank you, Mr. Chairman.

First, I would ask that my prepared statement be made part of the record.

Mr. MONTGOMERY. Without objection, so ordered.

Mr. SMITH of New Jersey. Thank you, Mr. Chairman.

[The prepared statement of Mr. Smith appears on p. 59.]

Mr. SMITH of New Jersey. Dr. Gronvall, one of the recommendations in the chairman's discussion draft legislation in section 4 would provide premium pay for LPN's and nurses assistants. On page 13 of your testimony, you suggested that provision would be unnecessary.

We know there is a shortage of nurses. Is there a shortage of LPN's and nurses aides, and could you expand upon your reason for opposing that provision?

Dr. GRONVALL. Yes, I will make a comment on the latter part of your question and then turn to my colleagues.

As a generalization, I think, nationwide, we have done better in recruiting nurse aides and licensed practical nurses than in recruiting registered nurses. If you look at the total employment data for our hospital system, to the extent that we have had some decline in total number of RN's, we have supplemented our work force by adding licensed practical nurses and nurse assistants. So, we have done relatively better in recruiting in those categories.

They are not interchangeable, of course, but the LPN's and nurse assistants do significantly supplement the strength of our nursing employees.

Mr. Kvasnicka, could you comment on the authority we have for LPN special pay?

Mr. KVASNICKA. We do have authority to pay—I assume we are talking about the Saturday premium pay and other premiums. We do have authority to pay that to LPN's on the same basis that we pay it to nurses provided there has been an established recruitment and retention problem at the facility.

Mr. SMITH of New Jersey. What authorities are different, then, that this would grant that is not in existing law? This would make LPN's and nurses aides identically treated as—

Mr. KVASNICKA. No. On the nursing assistants, we do not have any authority.

Mr. SMITH of New Jersey. Is that something that you think you need?

Dr. GRONVALL. I think Mr. Hendricks from the General Counsel's office could comment on that as well.

Mr. HENDRICKS. In the statement, we cited 38 U.S.C. 4107(f), as the authority to pay premium pay to LPN's on the same basis as for nurses. This authority is discretionary where recruiting or retention problems exist. As to LPN's, therefore, the bill is redundant. As to nurse's aides, it would be premature to say expanding our authority for premium pay is necessary. We have to study the data that we are still analyzing.

Mr. SMITH of New Jersey. So, that is why you are saying that—

Mr. HENDRICKS. That is why we are saying this would be redundant authority.

Dr. GRONVALL. Yes, as to LPN's we oppose the provision not because we think it is not a good idea but because we believe we already have the authority and are, in fact, exercising it. So, we don't believe it is a necessary legislative addition.

Mr. SMITH of New Jersey. I see. I have one final question, Mr. Chairman.

Perhaps Mr. Johnson might want to answer this, but do the physicians at the VA medical facilities also have to pay for parking? Is it all employees as you indicate in the testimony?

Dr. GRONVALL. In the instances where we will be charging, physicians will pay as well.

Mr. SMITH of New Jersey. Everyone.

Dr. GRONVALL. Yes, sir.

Mr. SMITH of New Jersey. Okay, thank you.

Mr. MONTGOMERY. Let me point out before recognizing you, Dr. Gronvall, we sent five staff members out a couple of weeks ago to go to 20 different veterans' hospitals. We will write a report, and it is rather shocking, that there is a nurse shortage in Augusta, Georgia. At the time of the nurse shortage, they closed 38 beds in the medical division and 19 beds in the surgical. That is 57 beds in Augusta, Georgia.

In Atlanta, Georgia, there were 57 beds in medical and 68 in surgical. That is 125 beds.

The report will show that because of nurse shortages, we are having to close these beds. We are very concerned about that.

Dr. GRONVALL. Mr. Chairman, I totally share your concern, and I very much appreciate the fact that many members of the staff did visit, and I look forward to the report. I get a regular report that is system-wide that documents beds that have been closed for all kinds of reasons, including staffing shortages. So I have those reports made to me on a regular basis.

In most of the instances when we look into the details of the operation at the medical center, they have been able to maintain the total number of veterans that they are caring for because the length of stay has been shortened. So, the total number of veterans who have been admitted to the hospital and cared for has been maintained.

However, I am not minimizing in any way the negative impact of the staff shortage. It is serious and significant. As I said to Mr. Rowland in response to his question, unfortunately, I believe on a national scale, it is going to get worse during the next couple of years.

We are just completing a second comprehensive survey that we have done ourselves on the specific number of staff vacancies at every one of our medical centers. The Office of Personnel is just putting the finishing touches on that, and I would look forward to receiving your report along with our own, and that helps us focus our efforts on special pay and the other incentives to try to focus them on the medical centers where we are having the greatest difficulty.

Mr. MONTGOMERY. Could we get those reports that you receive from these different medical centers?

I know it is not your fault, Dr. Gronvall. It comes from OMB, and that is why we need a Secretary of Veterans' Affairs so that we don't have to take orders from OMB.

But I don't believe you requested any bonuses or any incentives for nursing care in your fiscal year 1989 request, did you? I can't remember. I know we made the request to the Budget Committee and were turned down. Did you make a request?

Dr. GRONVALL. In the 1989 budget, there is partial reflection of the cost of special pay but not a request for bonus support.

Mr. MONTGOMERY. Well, you know, it is kind of frightening when you have 125 beds closed on that particular day because of some type of staff shortage. That is the best way to cut back expenses on the VA hospitals—close all your beds. Then we won't give any service other than outpatient clinic care.

Dr. Rowland?

Dr. ROWLAND of Georgia. Mr. Chairman, if you would yield for a moment—and I apologize to my namesake over there for taking his time—I do want to ask a question.

Dr. Gronvall, did you say that there was not a problem in providing care for the number of veterans that seek the care because of the cut back on the length of stay and various things? Is that what I understood you to say?

Dr. GRONVALL. Again, as we have—I wouldn't want to make it quite that sweeping—but as we have tracked month to month this year, we have continued to increase very slightly the total number of veterans who have been hospitalized. Even though the total number of beds that we are operating has shrunk, the reason we have been able to maintain and, in fact, slightly expand the number of veterans cared for in our hospitals is that the length of stay has continued to shorten.

Dr. ROWLAND of Georgia. You know, that is not exactly what I heard from Atlanta in talking with the people there. They are really clamoring because of the cut-back in the beds. We have talked about this before, and they are really upset about what is going on there and very concerned about being able to supply the medical care and hospitalization for veterans in that area.

So, that is of great concern to me. I wonder if you are finding out something different from what I am finding out in talking to the people?

Dr. GRONVALL. No. My response is in reference to aggregate data of the total number of veterans cared for in the entire hospital system. So, I am aggregating the data from 172 hospitals.

We do have particular geographic problems, and I would say, as a generalization, in the Southeast Sun Belt and in the Southwest

Sun Belt areas where the veteran population has been increasing rapidly, we have limitations in the total extent of our facilities and our ability to meet the demand for care on an equivalent basis, say, with the Northeast or the Midwest.

Dr. ROWLAND of Georgia. That is the problem. You know, we look at it nationwide and we don't take into consideration the geographic differences. I believe you are looking at it nationwide, and I am looking at it from the standpoint of the way it has affected in my area.

That is the way we do things so many times. We do the same thing with farming. We look at it nationwide and don't take into consideration the variations that the geographic areas cause.

That is a real problem, Mr. Chairman. It is really frustrating when you think about it.

Dr. GRONVALL. If I may, Dr. Rowland, add to that, the budget allocation system that we use is based on the actual work load at each individual medical center.

So, for example, the fact that we might have a medical center elsewhere in the country that was built 20 years ago with a certain number of beds, if their demand for work load is not up to that level, their operating budget reflects a lower level of support. Conversely, the medical centers with an expanding work load receive expanded operating support.

So, our allocation system in budgeting for our medical centers causes the money to go where the work load is. Similarly, in regard to staff recruitment, the special pay agreements relate to the local salary area. So, when we adopt those, we always collect the information about what is being paid in the surrounding institutions, and we make those decisions one by one on individual medical centers.

I am not trying to convince you that we don't have problems in medical centers. Mr. Montgomery asked for a copy of the report that I get that defines the number of beds closed throughout our hospital system, and we will submit that.

[Materials to be supplied appear on p. 50.]

Dr. ROWLAND of Georgia. This is all a chicken-and-egg thing, Mr. Chairman. You know, you cut down the facilities and that cuts down the work load. So, that cuts down more facilities. It is just like you said a while ago. If you close the hospital completely, you cut your expenses.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. You save a lot of money.

It really doesn't save a lot of money. Then the veteran has to get into Medicaid or Medicare, and we believe we have statistics to show that in the VA centers, you can treat these people at a more reasonable cost. Is that correct, Dr. Gronvall?

Dr. GRONVALL Yes, sir.

Mr. MONTGOMERY. We can do it more reasonably than if you push them into the Medicaid and Medicare system.

Dr. GRONVALL Yes, sir.

Mr. MONTGOMERY. John, we are glad to see you this morning.

The Chair recognizes the gentleman from Connecticut.

Mr. ROWLAND of Connecticut. Thank you, Mr. Chairman. I apologize for being late. I know that I probably received some demerits. Knowing of your interest in promptness, my apologies.

Quite frankly, you and Mr. Smith took a little bit of the thunder away from the issue that I wanted to address, and I am not going to be as nice or as diplomatic as the chairman or Mr. Smith from New Jersey in talking about the nursing shortage.

This is not the first time we have discussed this. I have been on this committee for three years, and each and every year, this issue comes up. I have to say that I am very upset to see what I think is an absolute avoidance of the issue.

In reading your testimony—and I didn't hear your comments during your testimony—I think it is an absolute cop-out to read that you have done some field survey studies in 1987 and that you don't support the chairman's position or the legislation because you haven't fully analyzed the data from this study. Therefore, you can't be definitive about the future needs or plans at that time, and because future study is necessary, we cannot favor the proposal.

Now, I am not the smartest guy in town, and I know my colleagues aren't because I have been working with them now for three years—

[Laughter.]

Mr. ROWLAND of Connecticut [Continuing]. But there is a nursing shortage. It is not a debatable issue. There is a nursing shortage within the VA and within the general hospital system. There is no question about that.

Pick up a newspaper in any part of the country. Go to the VA hospitals—and I know you have some studies and we are looking into it and nationwide or locally or by district or whatever the case may be, it is a very serious problem. I don't know, for the life of me, why you are avoiding that issue and why we are not addressing it.

The only admission you give here is that, well, in some areas or certain locations, it might improve recruiting and retention. I was in the business sector for a short time — and I think my colleagues will agree—more money is a great incentive for retention and keeping people and attracting people. There is no doubt about that in any industry. Nurses are no different.

I am adamant about pressing this issue, because it is going to be a real detriment in the short term and the long term. It is happening right now. I don't care if it is in the Northeast where we have a tremendous economy and tremendous competition. Every time I ever get near a VA hospital, they are talking to me about those problems, and I know that my colleagues have been discussing it.

So, to sit here and say we haven't fully analyzed the data from 1987 is a bunch of garbage. It is a problem. It is here today. If we don't do something about it, we are really going to be behind the eight ball in a couple of years, and I feel very strongly about.

I would like to know why you are not addressing it. I want to know why you are dancing with us on this and giving us the bureaucratic run-around. I think that usually you give us good straight answers, and we have worked together trying to resolve

problems. For some reason, I think you are ducking a very serious issue.

Dr. GRONVALL. Mr. Rowland, I categorically disagree with your conclusion that we do not recognize the problem and have done nothing about it. I think—

Mr. ROWLAND of Connecticut. Well, then, Dr. Gronvall, why haven't you analyzed the great study that you did in 1987—and that is why you oppose this, because it hasn't been fully analyzed.

Dr. GRONVALL. I think you have picked out one specific detailed legislative proposal and referred to our comment that we can't support it because we don't believe that we have an adequate analysis to show that the specific item will be necessary.

Before you came in, I had a chance in responding to the chairman and to Dr. Rowland to comment on a number of the things that we have done. Further, I made the point that I believe that the problem is going to get worse.

I have worked on the problem not only from the perspective of the VA but also the American Hospital Association and met with the leadership of national organizations that represent hospitals, nursing organizations, and nursing education.

I believe that we have worked extremely diligently, consistently, and across the board on a whole array of actions that we could take, and I believe the record will show that we have done better than most of the hospital chains or individual hospitals on protecting our staff.

We have in force at the present time well over 500 special pay agreements. The annualized amount of such special salary increments is just under \$100 million. We have adopted tuition support programs. We have reactivated our scholarship program. We have sought legislative expansion of that. We have supported a number of legislative initiatives that have been introduced in the Congress. We ourselves have introduced a number of legislative initiatives.

Again, I just categorically disagree with your conclusion that all we are doing is giving you a run-around or ignoring the problem. We have a significant number of staff people who are doing little else than working on a whole array of responses that we are making.

We have not found any way to wave a magic wand and have the problem go away, because there is an absolute shortage of nurses. Therefore, we are doing whatever we can to protect and recruit and retain the staff in our hospitals, and I think we have been significantly successful.

Mr. ROWLAND of Connecticut. I am just going to ask one final question.

Do you believe that there is a nursing shortage?

Dr. GRONVALL. Yes, sir. I think there is a very serious national nursing shortage that is going to get worse. If it were in the power of the VA to make that go away, I would wish that we could do it, but we are part of the national health system. So, we are doing our part to recruit and retain our own staff.

Mr. ROWLAND of Connecticut. Is there a nursing shortage within the VA?

Dr. GRONVALL. Yes, sir. As I have said repeatedly today, there is. Mr. ROWLAND of Connecticut. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, John.

There is one more question from the Chair.

This committee's staff went out, Dr. Gronvall, and they were told by the different directors that there were some problems on financing and that they really were not getting enough money to have proper health care. Are you aware of this situation?

Dr. GRONVALL. Yes, sir, because the directors talk regularly to me, and we have a field advisory council that represents the most talented of our directors with a representative structure from across the country. They had a meeting just a couple of weeks ago, so we sat through two days of intensive deliberation on the needs of our system, and I agree with the observation you have made.

Mr. MONTGOMERY. Can't you transfer some money over or find some monies in certain areas of health care to help out some of these hospitals where you think it is legitimate?

Dr. GRONVALL. Yes, we surely have made a number of special allocations this year. The total amount of money that we have to operate for this year is, of course, fixed, and the budget summit agreement that was entered into late last year means that there will not be any supplemental request made this year.

So, we are operating out of a known total appropriation, but we have made special allocations both for salary rates and for other special problems such as AIDS care to try to deal with the individual medical centers that have the most difficult problems.

Mr. MONTGOMERY. Thank you.

I am going to ask Dr. Rowland to take the chair. He only has one more question, and then we will hear from Mr. Bland who is the national commander of the Ex-Prisoners of War, and then we have one other panel.

Dr. ROWLAND of Georgia (acting chairman). I want to ask a question about supplemental appropriations. I guess it is a question about procedure as much as anything and why we didn't have supplemental appropriations for health care.

Can you address that for me?

Dr. GRONVALL. My understanding, Mr. Chairman, is that the so-called budget summit agreement that was reached last December between the Congress and the executive branch defined that all Federal programs that come under the rubric "discretionary" would not be subject to supplemental appropriation requests.

I should say, parenthetically, it is perhaps inappropriate that I hate the term "discretionary" because I do not consider veterans' health care a discretionary program. However, be that as it may, that is the definition that has been adopted for the veterans' health care part of the Federal budget.

So, our understanding is that no requests for supplemental appropriation support either in fiscal year 1988 or fiscal year 1989 will be submitted by the Administration.

There are supplemental requests which have been submitted and acted on for mandatory or entitlement programs, including the Veterans' Administration, but the entire health care system falls within that definition that prohibits supplemental appropriation requests.

That is a particular problem for us, Mr. Chairman, in regard to legislation that is, we believe, about to be signed by the President. I

am referring to H.R. 2616 which has now passed both the House and the Senate. That legislation, if signed by the President, will mandate a number of new activities in our hospital system.

We are analyzing the cost of that legislation. The major cost impact will occur in fiscal year 1989, but there will be some costs in fiscal year 1988, and we are attempting to define that cost. We will request appropriate support, but my understanding is that the Administration will not request supplemental appropriations for that legislative initiative.

Dr. ROWLAND of Georgia. Have you made any efforts to try to get it changed from discretionary to mandatory—the health care part of it?

Dr. GRONVALL. No, I can't say that we have in the sense that my understanding is that those definitions are set government-wide and they are across the board and divide the entire Federal operation on the basis of highly technical decisions or determinations in law as to where there was an entitlement created by the statute compared to where there is a discretionary program subject to availability of funds.

So, we have not attempted to change the definition.

Dr. ROWLAND of Georgia. I am advised by counsel here that Public Law 99-272 requires that hospitals be mandated and it is not discretionary.

Dr. GRONVALL. Mr. Hendricks maybe should help me on that.

Mr. HENDRICKS. I can't help you with regard to the government-wide definition, but, clearly, that law did make the providing of medical care to certain categories of veterans mandatory.

Dr. GRONVALL. If I may add—and I believe that my answer is correct—the eligibility statute clearly mandates that the Administrator shall provide care to veterans under certain circumstances, but the legal and fiscal judgments that I have had presented to me in the past indicate that that is subject to availability of funds or within the availability of funds and that that is what makes the entire program discretionary even though within a discretionary program, the law mandates care under certain circumstances, but that the entire program operates within availability of funds.

Dr. ROWLAND of Georgia. It seems to me that the bottom line is we continue to fight OMB. That seems to be our big problem.

Does anyone else have a question or comment?

Dr. GRONVALL. Mr. Chairman, it is unlike me to be here to defend OMB, but the budget summit agreement really was a mutual agreement between the Congress and the administration. So, it is a shared agreement responsive to the overriding desire to control the deficit. So, we are operating under an agreement that is between the Congress and the administration.

Dr. ROWLAND of Georgia. I wasn't referring just to the economic summit last year. I was referring to years past also.

Dr. GRONVALL. Yes, sir.

Dr. ROWLAND of Georgia. Counsel wants to ask a question.

Mr. McDONELL. Dr. Gronvall, I would just like to ask, inasmuch as Public Law 99-272 did mandate hospital care for certain veterans and H.R. 2616 will expand that mandatory care that you will provide in an outpatient setting, which will probably be a major portion of your medical care budget, have you discussed with your

counsel of going to OMB and getting a change to your medical care budget, at least a certain portion of it, under the classification as mandatory and not discretionary?

Dr. GRONVALL. Those discussions are currently underway. As I said, we are doing a cost estimate and have prepared a memorandum to portray the cost implications of implementation of H.R. 2616, and it is my intent to present that to the Administrator in a way that is intended to seek supplemental support.

Whether that will be successful or not, of course, depends on a series of decisions. However, from my standpoint, the statute mandates an expansion of care, and I feel it is my responsibility to seek the appropriate expansion of support to provide that.

Mr. McDONELL. Thank you.

Dr. ROWLAND of Georgia. Dr. Gronvall, thank you very much. We are not trying to beat up on you this morning as an individual. We are just trying to focus attention on the problems that we have.

Dr. GRONVALL. Mr. Chairman, I am well aware of that, and I very much appreciate the diligent oversight and continual support of this committee. It is a pleasure to be here, even though on a number of items, what I am here to portray is a problem which is not fully resolved. But I very much appreciate your support.

Dr. ROWLAND of Georgia. Thank you very much. I thank all of you very much.

Dr. GRONVALL. Thank you.

Dr. ROWLAND of Georgia. Our next witness is Mr. Albert Bland, national commander of the American Ex-Prisoners of War.

STATEMENT OF ALBERT J. BLAND, NATIONAL COMMANDER, AMERICAN EX-PRISONERS OF WAR

Mr. BLAND. Mr. Chairman, it is always an honor and a pleasure to appear before you and discuss our veterans' problems.

The four items we would like to discuss—and I will keep my statement short because of the time—include the extent of the alcohol and drug abuse treatment program from September 30, 1988 to September 30, 1989. We feel that it should be well beyond that, and we feel that it should be a permanent treatment because of the way of our modern times and everything else.

Regarding the extension of contracts and grants to the Veterans' Memorial Medical Center in the Philippines from 1989 to September 30, 1992, I believe this is a must. We have let those people down, especially the Scouts and mainly the Philippine Army. I fought side by side with those men, and I feel we have let them down, and we must continue their treatment over there.

Regarding clarifying the eligibility for extension of contract nursing home care for non-service-connected disability veterans, the VA Advisory Committee on Former Prisoners of War has documented the need for nursing home care services for former prisoners of war and recommended eligibility be clarified and broadened so as to serve these veterans. The American Ex-Prisoners of War endorse and support positive action on this matter and urge it be given the highest priority.

The fourth item in your main bill was the transfer of title of certain medical equipment without compensation which is now held

by specific State colleges and universities. We do not know enough about this, but in working with the universities and things like that, it would be heck of lot cheaper if we just wrote it off the books than having to go through the sales as they are required.

I have just come back from Portland, Oregon, and here is a brand new hospital that has a wing closed because it doesn't have enough personnel. That galls the daylights out of me. I wasn't going to say anything about this, but if we can find out and give \$20,000 to brothers and sisters of the men that beat the hell out of me, then I think we can find money to really fill all those hospitals out there.

There is a nursing shortage. You can go around to every hospital in the VA system, and you will generally find that wings have been closed because of lack of medical people. I burn on this subject when they are going to pay S. 1009.

I am sorry, sir, that I have lost my composure on that matter, but it really galls the daylights out of me.

Thank you very much, sir.

[The prepared statement of Mr. Bland appears on p. 61.]

Dr. ROWLAND of Georgia. I thought you were composed all right. I didn't find you discomposed at all there.

However, let me say, as you recently heard here just a few minutes ago, members of the committee staff visited several VA hospitals around, and the reports of the financial distress of these hospitals are very serious. We want to maintain a very high quality medical care system in our VA. We found out years ago that high quality is not only good for veterans, but it also served to attract good staff, too.

So, we cannot allow real threats to this system.

I want to thank you for your comments about the domiciliary program and agree with you that it is a good and useful program. This committee has helped with some expansion of the number of beds in domiciliaries, and we will certainly keep your thoughts in mind about that.

Mr. Stump?

Mr. STUMP. I have no questions, Mr. Chairman.

Dr. ROWLAND of Georgia. Mr. Rowland?

Mr. ROWLAND of Connecticut. No questions, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you very much, Mr. Bland.

Mr. BLAND. Thank you.

Dr. ROWLAND of Georgia. The next panel is Mr. Frank DeGeorge, associate legislative director of the Paralyzed Veterans of America; Mr. James Magill, director of the national legislative service of the Veterans of Foreign Wars; and Mr. David W. Gorman, assistant national legislative director for medical affairs of Disabled American Veterans.

Gentlemen, thank you very much for being here this morning. We will proceed in the order in which I introduced you.

Mr. DeGeorge, you may proceed in your own manner.

**STATEMENT OF FRANK DEGEORGE, ASSOCIATE LEGISLATIVE
DIRECTOR, PARALYZED VETERANS OF AMERICA**

Mr. DEGEORGE. Thank you, Mr. Chairman, and good morning to you and the members of the subcommittee.

PVA appreciates the efforts to conduct hearings and for being able to express our views and concerns regarding these most important issues that are contained in the legislative initiatives.

I will refer to the sections as indicated in the legislation as follows:

Mr. Chairman, PVA is pleased to support a one-year extension of the VA's alcohol and drug abuse treatment program. PVA believes the alcohol and drug abuse program is an integral part of comprehensive health care delivery. An effective treatment program, in conjunction with adequate follow-up and vocational rehabilitation, can lead to successful eradication of alcohol and chemical dependencies.

On section 2(b), PVA supports the extension of the VA authority to maintain a facility in the Philippines. We think it is important to maintain the stability of that entity in light of the nation's support of this important ally of the United States.

We have never seen any reports indicating that the treatment and services rendered by the VMMC are lacking. Therefore, additional funding should only be provided where the need can be substantiated.

On section 3, PVA reserves comment on this section. However, we do believe that this is a management decision for the VA to determine.

On section 4, to obviate additional future funding requests for appropriate staffing levels authorized by Congress, PVA is supportive of this amendment.

On section 5, PVA is supportive of this amendment, as PVA has, for many years, recommended premium pay and career opportunities to enhance the recruitment and retention of VA health care personnel. This amendment to authorize premium pay overtime for LPN's and nurse assistants who shall be treated in the same manner as registered nurses is, in PVA's opinion, positive and appropriate.

On section 7, PVA is supportive of this amendment and believes it is equitable and necessary. Its purpose serves as an incentive and mechanism for recruitment and retention in response to the critical need for registered nurses.

On section 8, PVA supports the amendment. The clarification and amendment of this section will further serve to provide additional potential recruitment and possible retention of VA health care personnel.

On section 8(b), there is a possibility that the potential of this legislation may open up a vast pool of untapped resources from the retired military sector, even if for part-time employment only.

PVA commends the efforts of this subcommittee to address the severe health care personnel shortages presently being experienced by the Veterans' Administration. We believe your efforts here today are an especially fitting tribute during this, that National Nurses Week.

On section 9, PVA opposes this amendment. Its enactment will give cause to serious and damaging effects on the morale of other VA employees not entitled to the waiver of payment of parking fees.

On section 10, we must express our serious concern with the current Federal regulations regarding eligibility for contract nursing home care for non-service-connected disabled veterans. PVA addressed its concerns in a letter to the Administrator which is contained in the full text of our testimony here today.

For the record, we reiterate our concerns and express our support to rescind this regulation.

Even more disturbing is the fact that the regulation is also applicable to service-connected veterans whose hospitalization was not primarily for service-connected disability. Certainly, this situation is contrary to the intent of Congress which, throughout the years, has demonstrated the highest commitment to this group of veterans.

On section 11, PVA is supportive of the purpose of sections 11(a) and 11(b), as we understand the equipment involved is either obsolete or in such poor condition that the costs of repair would be prohibitive. Enactment of this section would reduce the added administrative costs of return and/or transfer of equipment to the Veterans' Administration.

Mr. Chairman and members of the subcommittee, your continuing efforts to ensure that the veterans receive the quality health care they deserve is reinforced as exemplified by the draft legislation you have prepared and presented here today. In particular, it is apparent that you have recognized certain recommendations included in "An Independent Budget by Veterans for Veterans' Programs for Fiscal Year 1989." Your legislation today contributes to the recommendation by the AMVETS, DAV, VFW, and PVA for a multi-faceted program to enhance the VA's recruitment and retention of critical health care professionals.

Thank you, Mr. Chairman. That concludes my statement at this point.

[The prepared statement of Mr. DeGeorge appears on p. 67.]

Dr. ROWLAND of Georgia. Thank you, Mr. DeGeorge.

Mr. Magill?

STATEMENT OF JAMES MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MAGILL. Thank you, Mr. Chairman, for the opportunity to present the views of the Veterans of Foreign Wars with respect to proposed legislation which would enhance the VA's ability to recruit and retain health care personnel and also extend certain programs administered by the VA.

With respect to the extensions, the proposed bill before us today would extend until April 30, 1989 the VA's alcohol and drug abuse treatment program. While the VFW supports this extension, we would encourage the committee to consider making this vital program permanent.

The legislation would also extend the authority of the VA to make grants to the Republic of the Philippines. In order to ensure

the continued effective care and treatment of U.S. veterans in the VMMC, the VFW supports extending the grant program until September 30, 1992. We also support increasing the grant for fiscal year 1989 from \$500,000 to \$1 million.

Another provision of the draft bill would limit contracting for the integrated hospital computer system, and that would be, of course, for the evaluation of medical information through automated data processing, to no more than five VA medical facilities. The VFW is well on the record as supporting the more widespread DHCP program.

As stated at a hearing before this subcommittee on April 8, 1987, we believe DHCP is in place and working. We certainly do not oppose placing a cap on the number of hospitals which may implement IHS. However, we would much prefer to see no further expansion of IHS and retain its level to the three currently in place.

With respect to the recruitment and retention of VA health care personnel, the proposed bill contains several provisions. The proposed legislation would provide that any personnel of the VA whose salaries are paid with funds provided by the Department of Defense as reimbursement may not be counted for the purposes of any limitation on the number of full-time equivalent employees the VA may have for any fiscal year.

The VFW fully supports this provision.

Another provision would authorize premium pay for LPN's and nursing assistants on the same scale as is currently provided for registered nurses. The VFW applauds this provision as another step in making the VA more competitive with the private sector in the recruitment and retention of health care personnel.

Several other provisions of the legislation before us today would enhance the VA's recruitment and retention of health care personnel.

By allowing registered nurses who are appointed on an intermittent basis to receive the same flexible rates of pay as full-time nurses, clarifying that Title 5 employees who are paid under Title 38 may engage in employment outside the VA, not requiring VA registered nurses who are military retirees to forego a portion of their retirement benefits, and waiving parking fees for health care workers who are identified by the Department of Medicine and Surgery as hard to recruit and retain, the VA will be better able to attract high quality competent health care.

What is equally important is that these employees will opt to remain with the Veterans' Administration as it is providing a work, compensation, and benefit environment competitive with other hospitals and medical systems in the community.

The VFW supports these provisions and encourages their timely enactment.

With respect to community nursing home care facilities, the proposed legislation would maintain the flexibility currently provided the VA to extend reimbursement payments beyond six months for non-service-connected veterans in such facilities. The VFW supports this provision and would encourage the VA to continue to exhibit compassion in rendering extensions.

Finally, the draft bill would bestow title of various medical equipment to certain medical schools. The proposed legislation

would allow for the transfer of title to this equipment to the appropriate medical school so they may be able to acquire modern equipment. The VFW supports this provision also.

This concludes my statement. I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Magill appears on p. 78.]

Dr. ROWLAND of Georgia. Thank you, Mr. Magill.

Mr. Gorman?

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman.

It is certainly a pleasure to be here this morning, and the DAV certainly appreciates the opportunity to present our views on the pending draft legislation.

The DAV supports section 2(a) of the draft bill extending the VA's authority to provide treatment for substance abuse disabilities. This program has proven not only successful in the treatment and rehabilitation aspects of substance abuse but has also shown to be a most cost effective mechanism for providing such rehabilitation.

Section 2(b) also is supported by the DAV.

Mr. Chairman, the DAV is most appreciative of the subcommittee's continuing efforts to enhance the VA's ability to successfully recruit and retain certain health care personnel within the VA medical care system. As you are well aware, Mr. Chairman, the VA released their first survey of health occupational staff a little over one year ago. It is quite obvious that the VA, via the results of their own survey, experiences significant problems in recruiting and retaining various health care personnel crucial to the provision of direct health care services to disabled veterans.

In our view, the draft provisions go a long way toward enabling the VA to compete in the employment of certain health care providers by striving to make the agency an attractive employer. Therefore, we are able to support these sections dealing with recruitment and retainment enhancements.

Section 10 proposes the rescission of a proposed VA regulation, Code of Federal Regulations 17.51(a) to be effective on May 28 of this year, to limit any extensions of VA sponsored community nursing home care beyond the standard 6 months to not more than 45 days.

Quite frankly, we are unaware of any data that may exist relating to the actual numbers of veterans who may be potentially affected by the proposed regulatory change. Therefore, we find this issue particularly difficult to address at this particular time.

However, the proposed regulatory change, in our view, begs a much broader question, and that is exactly what is the VA's policy, if any, toward the long-term care needs of disabled veterans.

There are certain things that we are all aware of, and that is that virtually no new nursing home care bed construction has been requested by the VA. Virtually no conversions of acute care beds have been made to long-term care beds. And a significant shift of

long-term care to veterans in greater proportions has been directed to be provided by the private sector.

Mr. Chairman, it would be our recommendation at this time to the subcommittee that you give serious consideration to exploring the entire question of the VA's policy toward meeting the long-term care needs of veterans via the hearing process.

With respect to the proposed rescission of the regulation, we would suggest that a deferral of implementation of that regulation be made until such time as this much broader question can be addressed.

Mr. Chairman, that completes my oral remarks. Again, I would be glad to try to respond to any questions you may have.

[The prepared statement of Mr. Gorman appears on p. 82.]

Dr. ROWLAND of Georgia. Thank you very much.

Mr. Stump?

Mr. STUMP. Thank you, Mr. Chairman.

Mr. Gorman, would you please elaborate a little on the deterioration of the VA medical center in the Philippines if you could?

Mr. GORMAN. It appears from the information that we have had that over the years, the grants that have been made to the Philippines haven't been sufficient to enable the VA to keep up with the actual maintenance of the physical plant. Without having any real specifics as to exactly what projects have to be done, the sense that we are getting is that there is a significant deterioration of the physical plant that requires significant improvement at this time.

Mr. STUMP. Nothing really specific, though, that the complaints have been about?

Mr. GORMAN. No, it has just been a general sense that this is needed.

Mr. STUMP. Thank you.

I have one short question, Mr. Magill.

Do you believe that or do you share the VA's concern over the waiver of some parking fees and that it might have a bad morale effect on some of those who do have to pay?

Mr. MAGILL. We can see that may be a problem. However, we feel it is a step in the right direction. In fact, we did not support, I believe, at the time to charge the employees. We certainly believe that it, again, could cause a problem, but we think to retain and recruit hard to place employees that this would be warranted.

Mr. STUMP. Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you, Mr. Stump.

Mr. Rowland?

Mr. ROWLAND of Connecticut. Thank you, Mr. Chairman. I just have one question for Mr. Magill.

Jim, would you comment on the new 45-day rule on community nursing home extensions? Do you believe it will cause hardships on veterans?

Mr. MAGILL. Yes, sir, we do. There are quite a few veterans—and I think it has to be done on a case-by-case basis. We think that the VA has exhibited compassion in the past, and to place a mandatory limit of 45 days—I think Frank could probably address this even more with spinal cord injuries—that they should look at each individual patient.

Some of them, of course, may not need the 45 days. Others may need more.

Mr. ROWLAND of Connecticut. Would either of you other gentlemen like to comment?

Mr. DEGEORGE. I just would say that the regulations are too rigid, and I agree with Jim that case by case analysis and a look at the individual is important.

Going back historically, Paralyzed Veterans of America in the first place was opposed to non-service-connected veterans even going into nursing homes as well as being opposed to service-connected veterans going into nursing homes. Usually, the age difference as far as spinal cord injured or younger disabled veterans was the main concern as far as communications with older people who were in nursing homes, and that could have also been a problem for developing a staging to going out into the community.

Mr. ROWLAND of Connecticut. Dave, do you feel the same way?

Mr. GORMAN. Mr. Rowland, yes. I think that the 45 days definitely puts a restriction on the hospital directors that they may not need or want. In the same sense, I think, as we indicated in our written testimony, it begs a much broader question of what the VA's long-term care policy really is.

Is the six months really adequate, or should it be eight months or maybe a year? We don't know as of right now, and I think that does deserve further looking into.

Mr. DEGEORGE. Mr. Rowland, if I could, I do want to say one thing after hearing this morning's testimony. Dr. Gronvall said that the VA would try to do everything in their power to make sure that the person is not put into the street. I was encouraged to hear that, and I would hope that the regulations would be reflective of such actions.

Thank you.

Mr. ROWLAND of Connecticut. Thank you very much.

Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you, Mr. Rowland.

Mr. Magill, I want to thank you for your suggestion limiting the IHS sites to the three that are currently in place. As you know, it was in the report language that the Appropriations Subcommittee directed two additional sites. Therefore, the VA is not required to follow those directions.

So, we will certainly consider your thoughts on this matter.

Mr. Gorman, thank you for your suggestion of a hearing devoted to long-term care needs. We try to keep in mind the overall sense of VA policy in that regard, but you are correct to question taking piecemeal some of the VA's actions. Certainly, if you look at the small number of nursing home care beds together with this inflexible community nursing home regulation, you get kind of nervous about the capability of the VA to meet long-term care needs of the veterans.

Finally, let me say to all of you—and, Mr. Bland, let me say to you, too—that, as you know, on Monday we passed by a vote of 326 to 2 legislation to provide benefits for those veterans who were exposed to ionizing radiation, and the President has threatened to veto that.

Let me encourage all of you to write the President not to veto that and get your colleagues and other veterans' organizations, too, and just really get a push going to try to get him not to veto that. If he does, try to get a push on in the Senate where the vote was 30 to 48 to override the President's veto.

Thank you all very much for being here this morning.

The subcommittee stands adjourned.

[Whereupon, at 10:40 a.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

STATEMENT OF
JOHN A. GRONVALL, M.D.
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
MAY 4, 1988

Mr. Chairman, we are pleased to appear before the Subcommittee to present our views on a number of legislative proposals relating to the operations and personnel of the Veterans Administration health-care program.

Extension of the Alcohol and Drug Abuse Treatment Program

You first propose extending for one year, from September 30, 1988 to September 30, 1989, VA's authority to contract for care, treatment, and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based facilities for eligible veterans suffering from alcohol and drug dependence or abuse disabilities.

We strongly favor an extension of this authority but recommend that the legislation be amended to authorize this contract program on an ongoing basis, such as we proposed in legislation submitted to Congress on April 7, 1988.

2.

Through the use of halfway house contracts, veterans suffering from drug and alcohol abuse disorders, who begin treatment in a hospital detoxification ward, are able to continue rehabilitation in a supportive community-based environment. This helps facilitate the difficult transition back into the community at large.

Approximately 94 VA medical centers now participate in the drug and alcohol halfway house program and they administer approximately 400 contracts with non-VA community-based halfway house facilities. We found in a comprehensive evaluative study that the mean per diem rate paid by VA for halfway house care under this program is \$25, contrasted with an average estimated cost of \$93/day for alcohol dependence treatment and \$103/day for drug abuse treatment in VA programs and inpatient hospital care of \$175 per day. In addition to its cost efficiency, the contract rehabilitation program has demonstrated its effectiveness. Follow-up revealed a higher percentage of participants remained drug and alcohol-free for a longer period of time following their release from treatment than those whose treatment did not entail the contract approach.

3.

Also, for these veterans, full-time employment and income earned in part-time employment increased. A decrease in medical costs for non-alcohol related illnesses was noted. VA monitoring of this program during fiscal years 1984-1987 indicated that there is a continuing need for drug and alcohol abuse treatment and rehabilitation in the veteran community, particularly among Vietnam-era veterans.

The draft legislation we submitted to Congress also would eliminate the requirement for costly special evaluations. While these evaluations were initially helpful in assessing program viability, given the program's record of continued success, we believe that their purpose has been met, and that maintaining this requirement would not be cost-effective.

We estimate the cost of a one-year extension of this program to be \$10.1 million and \$50.6 million over the next five fiscal years.

Extension of the Contract Care and Grant Programs to the Veterans Memorial Medical Center, Philippines

The second proposal, which we also addressed in our draft bill of April 7, 1988, would extend through September 30, 1992, the

4.

authority of the President, with the concurrence of the Republic of the Philippines, to authorize the Administrator to contract with the Veterans Memorial Medical Center (VMMC) in Manila for medical care in the VMMC for eligible United States veterans.

The proposal would also extend for the same period the authority of the Administrator to make grants of up to \$500,000 annually to the VMMC for replacing and upgrading equipment and rehabilitating the physical plant.

We strongly favor extending both of these authorities. However, as provided in our proposal to Congress, we would recommend that these authorities be extended for an additional two years, through September 30, 1994.

We believe that authorizing VA to pay for care for U.S. veterans in the VMMC would enable the United States to fulfill its longstanding moral obligation to Filipino veterans who served in components of our Armed Services. Our Government undertook this obligation in 1948 when construction of the VMMC began, and Congress has continued to renew without interruption this authority out of concern that the Philippine Government, on its own, would be unable to provide high quality care to these U.S. veterans.

5.

We similarly believe that the grants to the VMMC are still needed to further assure that the facility is able to provide quality care to United States veterans by maintaining its complex in satisfactory condition and replacing and updating essential medical equipment and supplies. We would also note that our draft bill would require that \$50,000 of the annual grant be earmarked for the education and training of health-care personnel at the VMMC to help retain high quality staff.

Extension of VA Contract Nursing Home Care Authority for
Nonservice-Connected Veterans

A third proposal addresses to VA's authority to extend the provision of contract nursing home care to nonservice-connected disabled veterans and apparently seeks to rescind a recent VA regulation that would limit the duration of such extensions. We do not favor this proposal.

Section 620 of title 38 authorizes the Administrator to transfer to a community nursing home a nonservice-connected veteran who was furnished care in a VA medical facility but who still requires nursing home care. This provision is intended mainly to provide temporary assistance to a nonservice-connected veteran during a period of transition from hospital care.

6.

Congress emphasized the temporary nature of this contract care by providing that the duration of VA-paid community nursing home care for a nonservice-connected disabled veteran is limited to six months unless a longer period is warranted in the judgment of the Administrator. But it should be emphasized that this time limitation does not apply to nursing home care for service-connected disabilities.

It is clearly the intent of Congress that an extension of community nursing home care beyond six months for a nonservice-connected veteran is to be an exception and not the norm. To carry out this policy, VA recently published regulations clarifying the circumstances for granting these extensions.

Under these regulations, facility directors are authorized to grant an extension beyond six months when the veteran is terminally ill and life expectancy has been medically determined to be less than six months. Directors can also grant an extension of up to forty-five days when arrangements for non-VA sponsored nursing home care have been delayed unexpectedly. In the latter situation, authorizing a forty-five day extension helps clarify for all VA facilities the circumstances for an extension and also reduces the possibility of uneven application of this authority.

7.

- We believe that the 45-day extension period affords sufficient time to permit arrangements to be finalized for care.

Transfer of Medical Equipment Purchased under Chapter 82 Authority

The fourth proposal would authorize the Administrator to transfer without reimbursement or compensation the title to certain medical equipment purchased by the Administrator under the grant program for new State medical schools. We favor this proposal.

Public Law 92-541 authorized a program of grants to academic institutions which, in affiliation with VA facilities, would conduct programs of education and training in the health professions and occupations. Its provisions also specifically authorized VA to implement a pilot program to assist in the establishment of new State medical schools at colleges or universities if the schools are located in proximity to, and operated in conjunction with, VA medical facilities. This assistance includes the extension, alteration, remodeling, improvement, or repair of buildings and structures, and the purchase of equipment.

8.

Between 1974 and 1980, VA provided resources for the creation of five new state medical schools, which operate in affiliation with VA facilities and community hospitals. During this period VA purchased a wide variety of medical equipment and furnishings needed to establish and operate these medical schools. This equipment has always been located at the medical schools. The various kinds of equipment purchased over this period are now eight to fourteen years old. Many of these items are no longer usable and need to be replaced. Some of it has trade-in value, even though the amount may not be significant. But under current procurement laws, even if the equipment has no value at all, each item must still must be returned to VA, which must then turn it over to the General Services Administration for disposal.

Because of the limited value of this equipment, we believe that permitting the medical schools themselves to dispose of the equipment acquired under P.L. 92-541 would be more efficient and would actually result in cost savings, compared to following the current procurement process. For these reasons, we recommend approval of the proposal to transfer title of this equipment to the medical schools without requiring reimbursement to the Government.

9.

Waiver of Parking Fees for Certain Health-Care Workers

Another proposal would authorize the Administrator to waive, for health-care personnel in professions identified by the Department of Medicine and Surgery as difficult to recruit and retain, the payment of fees for parking at VA facilities charging these fees.

In 1986, Congress enacted legislation requiring that the VA collect fees from each employee or visitor parking at certain VA medical facilities. VA recently issued proposed regulations to implement this law. Later this year, after publication of the final regulations, the VA medical center at Chicago (Lakeside) will be the first facility to charge all employees for parking under that law.

Although we cannot predict the impact of granting relief from parking fees on the recruitment and retention of personnel in short supply health care occupations at any medical facility, we believe that taking this action could have a seriously adverse affect on morale among the other employees at the facility and could as well be detrimental to labor-management relations. Accordingly, we cannot favor this proposal.

10.

Integrated Hospital System

Let me now address the issue of the Integrated Hospital System (IHS) and expanding that system to additional VA Medical Centers. As you are aware, the Office of Technology Assessment (OTA) conducted a study comparing the DHCP and IHS systems. In response to that study, the VA was instructed by the House and Senate conferees to "create conditions under which future decisions are based on thorough and unbiased examinations of alternatives." VA plans to expand the IHS test by maintaining permanent test sites at the three existing IHS medical centers and by selecting two additional sites at tertiary care facilities to then serve as an ongoing bases for evaluating commercial technology. The expanded IHS test would be used to plan and evaluate innovative systems for VA users and management in the 1990's and beyond.

To facilitate this process, the Department of Medicine and Surgery will be preparing a functionally oriented solicitation that combines the best features of the current IHS applications with those of DHCP and provides for examining and installing future information systems innovations that are not known at this time. The new contract will be designed to allow the vendors to make necessary upgrades and implement continual

11.

technological innovations to the system throughout its life cycle. We also envision that the technology developed under the new IHS contract should be exportable to all VA medical centers.

We agree that IHS should be limited to the three existing centers and the two proposed at the tertiary care facilities.

The scope of the new IHS contracts will allow the Agency to migrate IHS technological innovations to DHCP sites thereby expanding their capabilities in future years. The proposed procurement will be conducted in accordance with the Brooks Act under a delegation of procurement authority from the Administrator of General Services.

Medical Personnel Proposals

Preserving Full Retired Pay for VA-Recruited Retired Military Nurses

Section 5532 of title 5, United States Code, now imposes upon retired officers of the regular components of the uniformed services, but not the reserve components, a substantial

12.

reduction in their retired pay when appointed to civilian positions in the Federal government. Naturally, this reduction would make employment with VA for retired military health care officers less attractive. However, VA now has authority, at section 4107(i) of title 38, to authorize exceptions to the statutory loss of pay for well-qualified physicians. Exercised infrequently and, we believe, prudently, the authority has nevertheless been particularly helpful in selectively recruiting highly qualified physicians in a variety of scarce categories. The proposal would enlarge the VA's authority so that it would include retired regular component military nurses as well. VA supports the proposal. However, we recommend that the Committee defer action on it since we have been advised that DoD has not had sufficient time to assess the impact of this legislation on its programs.

Accounting for FTEE Resources under VA/DoD Sharing Agreements

Another proposal before the Committee would exclude from VA FTEE ceiling controls personnel (both title 38 and title 5) who provide services to Defense Department medical facilities under

13.

agreements executed pursuant to the VA/DoD sharing act. We cannot support the principle of exempting from ceiling controls FTEE who are supported by appropriated funds. However, we would welcome the opportunity to work with DoD to examine systematically the extent to which there is a real disincentive to VA/DoD sharing.

Expanding Premium Pay

We believe that authority to provide premium pay to LPN's and nursing assistants is unnecessary. VA now has discretionary authority to pay LPN's (and other title 38 "hybrid" appointees) the same premium pay now authorized for nurses when necessary, as determined by the Administrator, for recruitment or retention. 38 U.S.C. § 4107(f). As to LPN's, the proposal appears redundant.

14.

As for non-title 38 health care appointees, including nursing assistants, early results from a 1987 field facility survey showed that expanding premium pay benefits in certain locations might improve recruiting and retention of some non-title 38 health care occupations. VA has not fully analyzed the data from this study, including the cost of expanding premium pay benefits, and we therefore cannot be definitive about future needs/plans at this time.

Because further study is necessary, we cannot favor the proposal.

Authorizing Pay Flexibility for Intermittent Nurses

With respect to the proposal on flexible pay rates for intermittent nurses, which we understand to contemplate premium pay flexibility for the position concerned and thus to reduce the need for contracts to secure nursing coverage, we note that VA currently has broad, flexible authority in statute to establish pay rates for temporary nurses, including intermittent nurses. 38 U.S.C. § 4114(a)(2). Thus, additional authority is not necessary. VA is now exploring how its existing authority to set pay rates can be used to avoid the need for contracting with private nursing concerns to provide necessary nursing care.

15.

Removing Moonlighting Prohibitions for "Hybrid" Employees

VA does not object to the proposal that would clarify that the moonlighting prohibitions do not apply to section 4104(3) hybrid employees. However, inasmuch as only certain specific title 38 pay and appointment authorities apply to these employees, VA believes that this proposal is unnecessary. VA is willing to clarify this through administrative means.

Mr. Chairman, this will conclude our formal testimony. My colleagues and I will be pleased to answer any questions you may have.

The following information provides a comparison of FY 1985 malpractice tort claims between the VA and private sector.

MALPRACTICE TORT CLAIMS

FISCAL YEAR 1985

<u>VA</u>	CLAIMS FILED/ 100 <u>PHYSICIANS</u>	PRIVATE SECTOR*	CLAIMS FILED/ 100 <u>PHYSICIANS</u>
Staff Full-time and Part-time All Categories of Privileges	6.7	Physicians - No Surgery No Obstetrical Procedures	9.2
12,518 Individuals		Physicians - Minor Surgery Minor Invasive Procedures	12.7
		Physicians Surgery--cardiac, cardiovascular, orthopedic, thoracic, traumatic and vascular	36.9
Staff Plus Residency Allocated Slots All Categories of Privileges	4.01	Physicians - No Surgery No Obstetrical Procedures	9.2
12,581 Above Plus 10,534 Slots		Physicians - Minor Surgery Minor Invasive Procedures	12.7
		Physicians Surgery--cardiac, cardiovascular, orthopedic, thoracic, traumatic and vascular	36.9

MALPRACTICE TORT CLAIMS

FISCAL YEAR 1985

<u>VA</u>	<u>CLAIMS FILED/ 100 PHYSICIANS</u>	<u>PRIVATE SECTOR*</u>	<u>CLAIMS FILED/ 100 PHYSICIANS</u>
Staff Full-time and Part-time Plus Individual Residents All Categories of Privileges	1.8	Physicians - No Surgery No Obstetrical Procedures	9.2
37,518 Individuals		Physicians - Minor Surgery Minor Invasive Procedures	12.7
		Physicians Surgery--cardiac, cardiovascular, orthopedic, thoracic, traumatic and vascular	36.9

(*Source: "Physicians' & Surgeons' Update, "Annual Report from The St. Paul - July 1986. St Paul Fire and Marine Insurance Company has been providing professional liability insurance to US physicians and surgeons for more than 50 years. This company is the nation's leading liability insurer. St Paul uses eight rate classifications. The "classes" are based on the risk factors of various medical specialties and the type of services and procedures the individual physician performs. The VA physician numbers used are for all employees and specialties without levels of risk or privileges.)

DM&S Inpatient Beds Closed due to Nursing Staff Recruitment Problems

As of the end of FYs 1986 and 1987 and the end of the second quarter of FY 1988, the following numbers of inpatient beds were closed as a result of nursing staff recruitment problems:

9/30/86	-	205
9/30/87	-	1890
3/31/88	-	2206

The three sets of attachments array the above numbers by individual health care facility and service area (i.e., ICU, medical, surgical, psychiatric, etc.)

Attachments



Beds Closed Due to Nursing Staff Recruitment Problems as of 9/30/86

<u>Facility</u>	<u>Total Beds</u>	<u>Medical Beds</u>	<u>Surgical Beds</u>	<u>Med/Surg Beds</u>	<u>Psych Beds</u>	<u>ICU Beds</u>	<u>NHCU Beds</u>
West Haven, CT	4					4	
Washington, DC	67	27	40				
Durham, NC	32		32				
East Orange, NJ	39			39			
Lyons, NJ	16					16	
Denver, CO	6					6	
Salt Lake City, UT	38	12			15		11
Martinez, CA	3					3	
Total	205	39	72	39	15	29	11
							51

Beds Closed Due to Nursing Staff Recruitment Problems as of 9/30/87

Facility	Total Beds	Medical Beds	Surgical Beds	Interned Beds	Psych. Beds	ICU Beds	Other Beds
Northampton, MA	39	6		13	20		
Boston, MA	125	50	62	2	11		
Brooklyn, NY	38		38				
Syracuse, NY	36		28			8	
Manchester, NY	53	31				2	NHCU 5
West Haven, CT	152	88	54			10	
Northport, NY	62	18	42			2	
Brockton/WR MA	93	42	26			1	SCI 24
Albany, NY	39	39					
Newington, CT	29		29				
Bedford, MA	89			49	40		
Bronx, NY	6					6	
New York, NY	1					1	
White River Jct., VT	8	4	4				
Durham, NC	101	32	61			8	
East Orange, NY	30	30					
Lyons, NJ	75				59	16	
Wilmington, DE	74		40				Neurology 34

Attachment #2

Beds Closed Due to Nursing Staff Recruitment Problems as of 9/30/87

Facility	Total Beds	Medical Beds	Surgical Beds	Intermed Beds	Psych. Beds	ICU Beds	Other Beds
Washington, D.C.	70	27	40			3	
Butler, PA	74	74					
Ft. Howard, MD	4	4					
Baltimore, MD	39	28	11				
Augusta, GA	67		55			12	
Atlanta, GA	68	20	48				
Lexington, KY	5					5	
Memphis, TN	3					3	
Nashville, TN	10					10	
Cincinnati, OH	81	8	52		8	4	Oncology 9
Ann Arbor, MI	37	31				6	
Madison, WI	4					4	
Chicago, (LS) IL	10					10	
Cleveland, OH	6					6	
Kansas City, MO	4					4	
Salt Lake City, UT	35	16	9			2	Detox 8
Palo Alto, CA	65				30	5	Neurology 30

Beds Closed Due to Nursing Staff Recruitment Problems as of 9/30/87

<u>Facility</u>	<u>Total Beds</u>	<u>Medical Beds</u>	<u>Surgical Beds</u>	<u>Intermed Beds</u>	<u>Psych. Beds</u>	<u>ICU Beds</u>	<u>Other Beds</u>
West LA, CA	116		30	30		11	NHCU 45
Roseburg, OR	23				23		
Loma Linda, CA	4					4	
San Francisco, CA	68	10	54			4	
Shreveport, LA	42	36				6	
Temple, TX	5					5	
Total	1890	594	683	109	191	158	155

Beds Closed Due to Nursing Staff Recruitment Problems as of 3/31/88

<u>Facility</u>	<u>Total Beds</u>	<u>Medical Beds</u>	<u>Surgical Beds</u>	<u>Psych Beds</u>	<u>ICU Beds</u>	<u>Intermed Beds</u>	<u>Other Beds</u>
Northampton, MA	39	6		20		13	
Boston, MA	169	59	57	22	7	2	Neur/Intermed 24
Brooklyn, NY	38		38				
Syracuse, NY	36		28		8		
Manchester, NY	38	31			2		NICU 5
West Haven, CT	160	72	64		10		Neurology 14
Brockton, MA	52	30					SCI 22
Newington, CT	20		20				
Bedford, MA	89			40		49	
Togus, ME	21	17			4		
Bronx, NY	85		79		6		
Montrose, NY	2				2		
New York, NY	4				4		
Albany, NY	16	16					

Beds Closed Due to Nursing Staff Recruitment Problems as of 3/31/88

<u>Facility</u>	<u>Total Beds</u>	<u>Medical Beds</u>	<u>Surgical Beds</u>	<u>Psych Beds</u>	<u>ICU Beds</u>	<u>Intermed Beds</u>	<u>Other Beds</u>
Durham, NC	132	57	67		8		
East Orange, NJ	30	30					
Lyons, NJ	75			59	16		
Wilmington, DE	40		40				
Washington, D.C.	70	27	40		3		
Butler, PA	51	51					
Lebanon, PA	12	10			2		
Richmond, VA	32	32			2		
Asheville, NC	40	40					
Ft. Howard, MD	4	4					
Baltimore, MD	45	34	11				
Augusta, GA	57		45		12		
Atlanta, GA	48		48				
Lexington, KY	2				2		
Jackson, MS	41	38			3		
Nashville, TN	12				12		
Cincinnati, OH	57	4	43		4		
Ann Arbor, MI	17	11					
							Oncology 3 ENT 3
							6

Beds Closed Due to Nursing Staff Recruitment Problems as of 3/31/88

Facility	Total Beds	Medical Beds	Surgical Beds	Psych Beds	ICU Beds	Intermed Beds	Other Beds
Madison, WI	6				6		
Chicago (LS), IL	6				6		
Chicago (WS), IL	40		40				
Cleveland OH	8				8		
Columbia, MO	4				4		
Salt Lake City, UT	25	12	9		2		Detox 2
Palo Alto, CA	48	14		30	4		
West LA, CA	142	8			10	90	NHCU 34
Roseburg, OR	23			23			
Loma Linda, CA	137	40	50		2		NHCU 45
San Francisco, CA	64	14	46		4		
Seattle, WA	8				8		
Shreveport, LA	42	36			6		

Beds Closed Due to Nursing Staff Recruitment Problems as of 3/31/88

<u>Facility</u>	<u>Total Beds</u>	<u>Medical Beds</u>	<u>Surgical Beds</u>	<u>Psych Beds</u>	<u>ICU Beds</u>	<u>Intermed Beds</u>	<u>Other Beds</u>
Houston, TX	76	1	33	37	6		
Phoenix, AZ	33		33				
New Orleans, LA	10				10		
Total	2206	655	829	231	187	152	152

OPENING REMARKS OF
HONORABLE CHRISTOPHER H. SMITH,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING ON MEDICAL LEGISLATIVE INITIATIVES
MAY 4, 1988

Thank you Mr. Chairman.

Mr. Chairman, thank you for scheduling this hearing to review various legislative proposals for FY '89. The focus of these proposals, Mr. Chairman, reflects the committee's strong commitment to ensure quality health care for our nation's veterans.

The provisions we are discussing today would help to improve health care services for veterans in several ways. For example, increasing employee benefits and pay, and removing obstacles which now prevent certain nurses from working at the VA, would greatly improve the working conditions at VAMCs and help to alleviate current staffing problems. In turn, delivery of direct patient care is improved and it is the veterans who ultimately benefit.

Additional initiatives under consideration today would expand VA authority to continue certain services. Contracting out services for drug and alcohol abuse treatment, for example, has proven to be beneficial for both the VA and the veteran seeking treatment. It is, therefore, in the interest of both the veteran and the VA to continue this project.

Mr. Chairman, the numerous provisions we are examining would clearly help to improve VA health care services. I look forward to hearing the views of our witnesses on these important issues.

STATEMENT OF THE HONORABLE MICHAEL BILIRAKIS

MAY 4, 1988

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

MR. CHAIRMAN, THANK YOU FOR SCHEDULING THIS HEARING ON SEVERAL MEDICAL LEGISLATIVE INITIATIVES AIMED AT IMPROVING THE HEALTH CARE DELIVERY TO AMERICA'S VETERANS.

I WISH TO WELCOME DR. GRONVALL, HE CHIEF MEDICAL DIRECTOR FROM THE VETERANS ADMINISTRATION, MR. DeGEORGE FROM THE PARALYZED VETERANS OF AMERICA, MR. MAGILL, FROM THE VETERANS OF FOREIGN WARS, AND MR. GORMAN, FROM THE DISABLED AMERICAN VETERANS.

I LOOK FORWARD TO HEARING THIS MORNING'S TESTIMONY ON PROPOSED LEGISLATION WHICH WOULD IMPROVE THE ADMINISTRATION'S ABILITY TO RECRUIT AND RETAIN QUALIFIED MEDICAL PERSONNEL. IN MY HOME STATE OF FLORIDA, THERE IS A CHRONIC SHORTAGE OF HIGHLY TRAINED, COMMITTED V.A. MEDICAL PERSONNEL. I WHOLEHEARTED ENDORSE THESE PROPOSED APPROACHES TO IMPROVE RECRUITMENT AND RETENTION OF HEALTH CARE PROFESSIONALS.

THE OTHER QUICK POINT THAT I WOULD LIKE TO COMMENT ON IS THE PROPOSED EXTENSION OF THE ALCOHOL AND DRUG ABUSE PROGRAM. I AM PLEASED THAT THE VETERANS ADMINISTRATION IS HERE BEFORE US THIS MORNING TO ALL ENDORSE THIS EXTENSION. IT SEEMS ALL TOO OFTEN THE V.A. IS NOT HERE TO FIGHT FOR AMERICA'S VETERANS BUT TO FIGHT AGAINST THEM.

THANK YOU MR. CHAIRMAN.

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STATEMENT BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES

BY

ALBERT J. BLAND, NATIONAL COMMANDER

AMERICAN EX-PRISONERS OF WAR

WITH RESPECT TO

MEDICAL LEGISLATIVE INITIATIVES

Washington, D.C.

MAY 4, 1988

WE EXIST TO HELP THOSE WHO CANNOT HELP THEMSELVES.

Mr. Chairman, and Distinguished Members of the Committee

We are pleased to have the opportunity to testify with respect to the four medical initiatives identified in your letter of April 22, 1988. In the spirit of these hearings, we have taken the liberty of adding one more possible initiative worthy of the thorough review and assessment upon which the Committee is embarked. Also, with the indulgence of the Committee, the following general observations are offered.

As we enter the last decade of this century, the medical care services of the Veterans Administration are facing major challenges. These derive from several factors, the changing nature and complexity of the health care delivery process, the changing demographics of the veteran population, and the changing character of the society in which we live.

A Committee similar to this one was established during WWII to prepare for the millions of returning veterans. It heeded veteran organizations' concerns that were voiced so unselfishly by leaders who were veterans of WWI. Those concerns focused on the need for a nationwide VA system of hospitals and clinics that would provide the best quality of medical care possible. Congress responded by enacting legislation and providing resources that did enable VA to establish high quality care and rehabilitative services. In partnership with medical and nursing schools—and other academic programs for a full range of health care professionals and technicians—VA's health care system became recognized for its leadership, not only in the

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delivery of quality medical services, but also in the training of health care professionals and in research and evaluation. Veterans will be forever grateful for Congressional initiatives which made this all possible.

The Department of Medicine and Surgery of the VA was determined to maintain that high level of functioning and did so for many years. However, there is increasing concern that a gradual but accelerating erosion in the quality of care and related functions is occurring. Certainly it is true that veterans, individually and collectively, have much less confidence in the ability of VA to maintain that quality of care. We do not doubt VA's desire but cannot help but note the decreasing capacity to do so.

The level of resource support for today's general health care service has not entirely kept pace with today's increasing costs and sophisticated technological advances. The consequence is the growing inability of VA to attract—and retain—high quality health care professionals. The bottom line is the danger of poorer care to veterans. Despite expected reassurances from top VA officials, concerned individuals with extensive firsthand experience in specific VA medical facilities over a period of time do observe a changing atmosphere in those facilities—and a diminishing quality of care provided.

Beyond that basic problem is another resulting more specifically

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from the aging veteran population. It confronts the VA with very different but equally complex treatment and rehabilitation problems. Since this mirrors trends in our society in general, VA—with proper resources—could again play a leadership role in this area. This challenge is compounded by the increasing number of homeless or impoverished veterans who have few viable options for acute, chronic, or rehabilitative services. It should be recognized research has shown that reduced coping skills in later life are associated with the long-term emotional trauma that resulted from extended combat or prisoner of war experiences. As a result, many of these deserving veterans find themselves in increasingly desperate circumstances.

Lastly, is the tragic but growing problem in our society of substance abuse. Veterans are not spared its impact. Just as unresolved anxieties contributed to the abuse of alcohol in prior generations of veterans, so do they for our newer veterans. The special programs funded by Congress in the past and implemented by VA on a national basis has helped many thousands of veterans and their families cope with the consequences.

Mr. Chairman, I would now like to turn to the four initiatives identified by the Committee. My comments will be brief since my preceding remarks have collectively indicated their importance for the immediate and long-range future.

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I Extending the Alcohol and Drug Abuse Treatment Program from September 30, 1988 to September 30, 1989.

The American Ex-Prisoners of War strongly supports this initiative. However, we would urge the Committee to project this program well beyond September 30, 1989 and note that the staff recruitment and retention is adversely affected by uncertainty concerning the continuation of the program.

II Extending Contracts and Grants to the Veteran Memorial Medical Center in the Philippines from September 30, 1989 to September 30, 1992.

We feel particularly qualified to strongly endorse the intent of this initiative since so many of our members shared the hardships and suffering of Filipino veterans during the dark days of World War II in that theater of operations. We do not have the technical information to be more specific in our support.

III Clarifying Eligibility for Extension of Contract Nursing Home Care for NSC Disabled Veterans.

The VA Advisory Committee on Former Prisoners of War has documented the need for nursing home care services for former prisoners of war, and has recommended eligibility be clarified and broadened so as to serve these veterans. The American Ex-Prisoners of War endorse and support positive action on this matter and urge it be given the highest priority.

IV Authorize the Administrator to Transfer Title to Certain Medical Equipment Without Compensation Now Held by Specific State Colleges and Universities.

We do not have sufficient information to make a specific recommendation on this initiative. However, we would assume that such transfer of ownership would be based either on no longer needing the equipment, or would have the continuing assurance that it would still serve veterans where needed. We further assume that these schools have participated with VA in mutual training and service objectives. If these assumptions are essentially correct, we would have no objection to the action proposed in this initiative.

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Mr. Chairman, as I indicated earlier, we would like to add one initiative to the four already identified by the Committee. It concerns the VA Domiciliary Program. This little-noticed program has benefited countless numbers of veterans from WWII down to the present. Many veterans require a sheltered environment to which they can contribute on a volunteer and/or limited pay basis. However, laws have been passed over the past 35 years which unnecessarily limit the ability of VA to operate these programs. Similarly, VA's current method of tying dollar support to length of stay for specific diagnostic categories prevents those facilities from establishing domiciliary or rehabilitation beds which involve long-term stays and minimum medical care. This was not true in the past when support was tied to bed occupancy rates. A number of facilities had small domiciliary/rehabilitation units that cost VA very little but were therapeutic to the veterans involved and productive to those medical centers.

We urge the Committee to look closely at this low-cost but effective program that can be particularly relevant to the veteran population we have described before. An initiative to preserve and extend it is fully warranted.

In closing, Mr. Chairman, we believe many initiatives can be enacted with flexibilities in structure to hold down costs without sacrificing quality of care. Greater self-responsibility for veterans in all of VA's health care programs is possible. It can be achieved without lowering quality of care but with far greater quality of life for those veterans being served.

Thank you.



PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING

Proposed legislation to amend title 38, United States Code,
to improve programs for the recruitment and retention
of health-care personnel of the Veterans Administration,
to extend certain expiring programs of the Veterans Administration,
and for other purposes.

This Act is cited as the
"VETERANS' HEALTH CARE PROGRAMS AMENDMENTS OF 1988."

MAY 4, 1988

Mr. Chairman and Members of the Subcommittee, I am Frank R. DeGeorge, Associate Legislative Director of Paralyzed Veterans of America, and on behalf of the members of Paralyzed Veterans of America, a congressionally chartered veterans' service organization, I want to thank you for affording me the opportunity to appear here today.

FVA appreciates the Subcommittee's efforts to conduct hearings, and for being able to express our views and concerns regarding these most important issues.

SEC. 2. EXTENSION OF EXPIRING PROGRAMS

(a) ALCOHOL AND DRUG ABUSE TREATMENT

Mr. Chairman, FVA is pleased to support extension of the VA's alcohol and drug abuse treatment program from September 30, 1988, to September 30, 1989. Section 620(a) of title 38 U.S.C. gives the Administrator discretionary authority to contract with community based, non-VA facilities for the treatment and rehabilitation of eligible veterans with alcohol and drug dependencies.

FVA believes the alcohol and drug abuse program is an integral part of comprehensive health care delivery. An effective treatment program, in conjunction with adequate follow-up and vocational rehabilitation, can lead to successful eradication of alcohol and chemical dependencies.

As you know, the program was originally enacted in 1979 as a pilot program. The program was extended in 1985, as a result of Public Law 99-166 (H.R. 505). The action we are presently considering will represent the second extension of a program which, by now, we should have enough information by which to either make it permanent or support its expiration.

Public Law 99-166 required the Administrator of Veterans Affairs to furnish to Congress a report detailing the cost and effectiveness of this program. The report was due in February of this year, but as often is the case, it was

late. It was not until April 29, 1988, that the report was ready for dissemination to Congress. Unfortunately, we have not had adequate time in which to analyze the details contained in the report. As a result, PVA, as well as the Congress, has no reliable method by which to judge the effectiveness of this program until such time that we are able to analyze the report.

PVA is hopeful that the report will contain positive results regarding the success of the VA's alcohol and drug treatment program. Should this hope be realized, we will be fully supportive of legislation to establish the vital services rendered by this program as permanent.

The purpose of this program is, not only required, but extremely invaluable to the veteran. We question whether the program is conducted in a valid and properly supported manner. We feel it is underfunded, thus serving as a token program. There is evidence that the program is poorly managed, overcrowded, and with a long waiting list. Veterans are referred to Outreach Centers for treatment rather than being provided with contracted private sector services. It appears that the program has become only an employment/work placement program. We feel a limited extension of this program is in order until its effectiveness can be fully determined.

(b) VETERANS MEMORIAL MEDICAL CENTER IN THE PHILIPPINES

PVA supports the extension of the VA authority to maintain a facility in the Philippines. We think it is important to maintain the stability of that

entity in light of the nation's support of this important ally of the United States.

We have never seen any reports indicating that the treatment and services rendered by the VMHC are lacking. Therefore, we can only question the purpose for increased funding. Under today's austere conditions, these added monies can only dilute the current level of services provided this nation's veterans. Additional funding should only be provided where a demonstrable need can be substantiated.

SEC. 3. LIMITATION ON CONTRACTING FOR THE INTEGRATED HOSPITAL SYSTEM

PVA reserves comment on this Section. We believe that this is a management decision for the VA to determine.

SEC. 4. EXCLUSION FROM PERSONNEL CEILING.

To obviate additional future funding requests for appropriate staffing levels authorized by Congress, PVA is supportive of amendment of Section 5011(d) of title 38, U.S.C., by adding at the end the following new paragraph:

"(6) Any personnel of the Veterans Administration whose salaries are paid for with funds provided by the Department of Defense as reimbursement under an agreement under this subsection may not be counted for the purposes of any limitation on the number of full-time equivalent employees that the Veterans Administration may have for any fiscal year."

SEC. 5. PREMIUM PAY FOR LICENSED PRACTICAL NURSES AND NURSE ASSISTANTS.

PVA is supportive of amendment to Section 4107(e) of title 38, U.S.C. PVA has, for many years, recommended premium pay and career opportunities to enhance the recruitment and retention of VA health-care personnel. This amendment to authorize premium pay (overtime) for LPN's and Nurse's Assistants, who shall be treated in the same manner as registered nurses, is, in PVA's opinion, positive and appropriate. Private-sector hospitals with which the VA must compete for the ever-dwindling pool of health-care personnel have been offering premium pay for many years. This amendment is a welcome personnel policy change which is long overdue.

SEC. 7. FLEXIBLE RATES OF PAY FOR CERTAIN NURSES.

PVA is supportive of the amendment to Section 4107 of title 38, U.S.C., by adding the following new subsection: _

"(j) Registered nurses appointed on an intermittent basis may be paid under subsection (e) of this section on the same basis as nurses appointed on a full-time basis."

PVA believes this amendment to be equitable and necessary. Its purpose serves as an incentive and mechanism for recruitment and retention in response to the critical need for registered nurses.

SEC. 8. CLARIFICATION OF CERTAIN LIMITATIONS WITH RESPECT TO EMPLOYMENT.

(a) LIMITATIONS OF OUTSIDE EMPLOYMENT.

PVA supports the amendment of Section 4108 of title 38, U.S.C., by adding at the end the following new subsection:

"(e) Any provision of this title limiting employment outside of the Veterans Administration by an employee of the Veterans Administration shall not apply to an employee who is appointed under the provisions of title 5 and paid under the provisions of this title."

PVA believes that the clarification and amendment of this Section will further serve to provide the potential recruitment and possible retention of VA Health Care personnel.

Although PVA is supportive, it is most important that the Administrator provide assurances, by enactment of this provision, that he recognizes that quality medical care is imperative and inpatient/outpatient treatment of the veteran must not be endangered by staff who are overtired, overburdened and overworked.

(b) COMPENSATION OF EMPLOYEES WHO ARE RETIRED MILITARY PERSONNEL.

(1) Such section is further amended by adding after subsection (e), as added by subsection (a), the following new subsection:

(f) An employee of the Veterans Administration who is a registered nurse shall be paid in accordance with the provisions of this chapter without regard to any provision of law with respect to reductions in compensation for employees who are entitled to receive military retired pay.

There is a possibility that the potential of this legislation may open up a vast pool of untapped resources from the retired military sector, even if for part-time employment only.

PVA commends the efforts of this Committee to address the severe health-care personnel shortage presently being experienced by the VA. We believe your

efforts here today are an especially fitting tribute during this, National Nurses Week.

PVA supports this amendment on the basis of the critical shortage and need for registered nurses in the Veterans Administration, as we have previously and repeatedly stated.

SEC. 9. WAIVER OF PARKING FEES FOR CERTAIN HEALTH CARE WORKERS.

(a) In General.--Section 5009(c) of title 38, U.S.C., is amended--and the following new paragraph is added:

(3) A parking fee shall not be charged under this subsection in the case of any health care employee who is eligible for an increase in basic pay under section 4107 (g)(1) of this title.

PVA opposes this amendment. Its enactment will give cause to serious and damaging effects on the morale of other VA employees not entitled to the waiver of payment of parking fees.

SEC. 10. COMMUNITY NURSING HOMES.

We must express our serious concern with the current federal regulations regarding eligibility for contract nursing home care for nonservice-connected disabled veterans. PVA addressed our concerns in a letter to the Administrator dated August 19, 1987. Specifically, PVA is opposed to the revision of §17.51(a) of title 38 CFR, published in the Federal Register on April 21, 1988, (53 Fed. Reg. 13120). For the record, we reiterate our concerns and express our support TO RESCIND this regulation. Our letter read:

The placement of an inflexible forty-five day cap on nonservice-connected veteran extensions beyond six (6) months, mandating the

transfer of the veteran to a community nursing home unless the veteran is terminally ill and life expectancy has been medically

determined to be less than six (6) months, is too rigid. The proposal fails to take into consideration the potential that suitable community nursing home care to which a required transfer can be made may not be available under all circumstances. When considering that the elderly population is growing at a rapid rate, and competition for limited community resources is becoming more extreme each year, the revision proposed in essence will force NSC veterans out of the system, with no place to go.

Although the VA has long recognized the pending problem concerning nursing home care for the growing elderly NSC veteran population, we construe the intent of the proposed revision as another stop-gap measure to relieve the anticipated pressure on the VA nursing home system in the future, instead of planning an appropriate solution to resolve the developing dilemma. More appropriately, the proposed 45 day limitation provided for in the regulation should be tempered by adding a provision that NSC veterans for whom suitable/adequate accommodation cannot be identified in local community nursing homes can be retained until such time as the veterans' needs can be accommodated.

Understandably, this provision will create hardships on some VA nursing homes. However, it is PVA's opinion that now is the time for the VA, in coordination with other government and community agencies, to formulate realistic solution to a problem that can only be expected to become more intense with each passing year. Until a viable solution is found, the proposed revision should be held in abeyance, or modified as indicated. To do otherwise will be to the detriment of many needy NSC veterans, and an admission by the Veterans Administration that their concern with the plight of NSC veterans is secondary to dollar savings.

Despite our concerns, the VA made final implementation of the regulatory amendment on April 21, 1988, with the effective date of May 23, 1988.

Even more disturbing is the fact that the regulation is also applicable to service-connected veterans whose hospitalization was not primarily for a service-connected disability. Certainly, this situation is contrary to the intent of Congress which, throughout the years, has demonstrated the highest commitment to this group of veterans.

A service-connected veteran, compensably rated at 50% or more, who is admitted with a nonservice-connected diagnosis may very well be in need of nursing home care in excess of six months and 45 days. Any medical problem in a catastrophically disabled veteran, no matter how seemingly simple to an able-bodied person, can be enormously complex when compounded by a catastrophic disability. Yet, the regulation, as written, is so rigidly inflexible as to deny care to this otherwise eligible veteran.

SEC. 11. TRANSFER OF TITLE TO CERTAIN MEDICAL EQUIPMENT.

(a) Authority.--Notwithstanding any other provision of law, the Administrator of Veterans' Affairs may transfer all right, title, and interest of the United States in and to any medical equipment described in subsection (b) to the college or university holding such equipment on the date of the enactment of the Act. Any such transfer shall be without compensation or reimbursement to the United States.

(b) Medical Equipment Covered.--This section applies with respect to medical equipment acquired by the Administrator for the purposes of the pilot program established under subchapter I of chapter 82 of title 38, U.S.C., and made available by the Administrator to a State college or university as part of the assistance provided that college or university under section 5073(a) of such title.

PVA is supportive of the purpose of Sec. 11. (a) and (b) as we understand the equipment involved is either obsolete or in such poor condition that the cost of repair would be prohibitive. Enactment of this section would reduce the added administrative costs of return and/or transfer of equipment to the Veterans Administration.

Mr. Chairman and Members of the Subcommittee, your continuing efforts to ensure that the veterans receive the quality health care they deserve is

reinforced as exemplified by the draft legislation you have prepared and presented here today. In particular, it is apparent that you have recognized certain recommendations included in "An Independent Budget by Veterans for Veterans' Programs for Fiscal Year 1989." Your legislation, today, contributes to the recommendation by the AMVETS, DAV, VFW and PVA for a multifaceted program to enhance the VA's recruitment and retention of critical health care professionals.

The First Session of this Congress brought forth many legislative initiatives designed to address the VA's critical shortages.

PVA has testified before you on several occasions and we reiterate the need for a multi-dimensional approach to this problem. No stand-alone, quick-fix solution can address the individualized, specific needs of the different professions where shortages are apparent. Each has its own unique professional requirements which result in recruitment and retention problems specific to that profession.

Congress and your Committee are to be commended for your efforts; however, the only workable solutions must combine both legislative and administrative initiatives. The VA needs to take an active role to engineer a variety of creative solutions which address both long-term and quick-fix results. It is up to the management of the VA to create an atmosphere in which health care professionals would want to work and remain working. The VA must provide competitive salaries, greater educational opportunities and opportunities for career advancement and mobility. But most importantly, the VA must

demonstrate a commitment to the professionals themselves and to the provision of quality care to our Nation's veterans.

From PVA's perspective, the VA has not even taken the most essential step in attempting to address the Agency's widespread shortages. PVA continues to ask, "Where Are The Agency's Staffing Guidelines?" The VA cannot be expected to be able to allocate adequate funds for recruitment and retention measures when they do not even know how many authorized Full Time Equivalent Employments are appropriate: PVA believes that sound staffing guidelines are so important and so necessary that Congress should mandate that the VA conclude its guidelines immediately. Adequate staffing is the first step toward ensuring quality of care.

On behalf of PVA and its members, I want to express our appreciation to you and your dedicated staff for your continuing concern for our nation's veterans. Mr. Chairman, this concludes my statement. I will attempt to answer any questions you may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES



STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

LEGISLATION PROVIDING FOR IMPROVEMENT IN PROGRAMS TO
RECRUIT AND RETAIN HEALTH-CARE PERSONNEL AND
EXTEND CERTAIN OTHER VA PROGRAMS

WASHINGTON, D. C.

MAY 4, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to appear before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars with respect to proposed legislation which would enhance the Veterans Administration's ability to recruit and retain health-care personnel and also to extend certain programs administered by the VA. The VFW is appreciative of your holding this hearing and demonstrating your continuing concern for the health-care needs of our nation's veterans.

The proposed bill before us today would extend, until September 30, 1989, the VA's Alcohol and Drug Abuse Treatment Program. Under title 38, the

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Administrator may contract for care, treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This authority is due to expire September 30, 1988. While the VFW supports this extension, we would encourage the Committee to consider making this vital program permanent. It has been extremely successful and, quite obviously, the need will continue to exist.

The legislation would also extend the authority of the VA to make grants to the Republic of the Philippines so as to provide for the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the Veterans Memorial Medical Center (VMMC). Construction of the Center was authorized in 1948 and the facility is now approximately 34 years old. In order to ensure the continued effective care and treatment of U.S. veterans in the VMMC, the VFW supports extending the grant program until September 30, 1992. We also support increasing the grant for FY '89 from \$500 thousand to \$1 million.

Another provision of the draft bill would limit contracting for the Integrated Hospital System (IHS) for the evaluation of medical information through automated data processing to no more than five VA medical facilities. The VFW is well on record as supporting the more widespread Decentralized Hospital Computer Program (DHCP). As stated at a hearing before this Subcommittee on April 8, 1987, we believe DHCP is in place and working. We certainly do not oppose placing a cap on the number of facilities which may implement the IHS system; however, we would much prefer to see no further expansion of this system and retain its level to the three currently in place.

The proposed legislation would also provide that any personnel of the

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Veterans Administration whose salaries are paid with funds provided by the Department of Defense as reimbursement may not be counted for the purposes of any limitation on the number of fulltime equivalent employees the VA may have for any fiscal year. The VFW fully supports this provision inasmuch as these employees are not paid by the VA and, therefore, do not impact on the VA's appropriation.

Another provision would authorize premium pay for licensed practical nurses and nurse assistants on the same scale as is currently provided for registered nurses. The VFW applauds this provision as another step in making the VA more competitive with the private sector in the recruitment and retention of health-care personnel.

Several other provisions of the legislation before us today would enhance the VA's recruitment and retention of health-care personnel. By allowing registered nurses who are appointed on an intermittent basis to receive the same flexible rates of pay as fulltime nurses; clarifying that title 5 employees who are paid under title 38 may engage in employment outside the VA; not requiring VA registered nurses who are military retirees to forego a portion of their retirement benefits and, waiving parking fees for health-care workers who are identified by the Department of Medicine and Surgery (DM&S) as hard to recruit and retain, the VA will be better able to attract high quality competent health-care personnel. What is equally important, these employees will opt to remain with the Veterans Administration as it is providing a work, compensation and benefit environment competitive with other hospitals and medical systems in the community. The VFW supports these provisions and encourages their timely enactment.

With respect to community nursing home-care facilities, the proposed

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legislation would maintain the flexibility currently provided the VA to extend reimbursement payments beyond six months for nonservice-connected veterans in such facilities. The VA has recently implemented regulations that would limit the extension to 45 days. The VFW supports rescinding the regulation and would encourage the VA to continue to exhibit compassion in rendering extensions.

Finally, the draft bill would bestow title of various medical equipment to certain medical schools. It is our understanding the VA has purchased medical equipment to assist in establishing new state medical schools. Under the agreement, the VA retains title to the equipment and, therefore, the medical schools cannot dispose of such equipment when it becomes outmoded. The proposed legislation would allow for the transfer of title of this equipment to the appropriate medical school so they may be able to acquire modern equipment. The VFW supports this provision.

Mr. Chairman, this concludes my testimony. I will be happy to respond to any questions you may have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
May 4, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to have the opportunity to appear here today to discuss various issues relating to the Veterans Administration's health care system as contained in the pending draft legislation.

Section 2(a) of the draft legislation would amend Section 620A(e) of Title 38, United States Code (USC), extending for one year, until September 30, 1989, the VA's authority to provide treatment and rehabilitation services for alcohol or drug abuse disabilities in community-based treatment facilities, such as halfway houses.

Mr. Chairman, the VA has recently transmitted its final report -- as mandated by Public Law 99-166 -- to the Congress on the evaluation study of the contract program for veterans with alcohol and drug dependence disorders.

Following our review of this program evaluation, we are persuaded the program functions as an important augmentation to the VA's overall treatment of veterans suffering substance abuse disabilities. Therefore, the DAV has no objection to favorable consideration of this provision.

Section 2(b) proposes, via appropriate amendment to Section 632, Title 38, USC, to extend the authority for grants to the Veterans Memorial Medical Center, Republic of the Philippines, until September 30, 1992; and increase the amount of such grant from \$500,000 to \$1 million for Fiscal Year 1989.

As you are aware, Mr. Chairman, the purpose of this grant authority is to assist in the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the medical center.

It is our understanding there exists a significant need to rehabilitate the deteriorating condition of the medical center. Therefore, if this is indeed the case, the DAV has no objection to favorable consideration of Section 2(b).

Section 3 of the draft bill would place a limit on contracting for the Integrated Hospital System (IHS) evaluation of medical information systems -- automated data processing -- at no more than five (5) VA medical facilities.

As you know, Mr. Chairman, IHS now serves three (3) VA medical centers. It is our understanding the VA is in the process of selecting two (2) additional VA medical facilities to serve as a permanent base -- for a total of five (5) facilities -- for evaluating commercially available systems and tracking changes in the technology offered by commercial vendors.

Although the DAV has no official position, we have no objection to favorable consideration of this provision.

Section 4 proposes amendment to Section 5011(d) Title 38, USC, by adding a new paragraph to exclude from the VA's authorized personnel ceiling for full-time equivalent employees any employee whose salary is paid for with Department of Defense funds as reimbursement under any existing sharing agreement.

Mr. Chairman, as you are well aware, a perennial proposal in the VA's budget request is the arbitrary reduction of direct health care personnel which equates to an adverse impact on the level of health care provided to disabled veterans. Section 4 would, in our view, offer a degree of assistance in ensuring that adequate numbers of VA health care personnel are maintained to carry out the agency's mandated mission of providing medical services to eligible disabled veterans.

Mr. Chairman, the DAV is appreciative and applauds your effort to enhance the recruitment and retention of health care personnel via this draft legislation, to wit:

- o authorize premium pay for licensed practical nurses and nursing assistants (Section 5);
- o authorize flexible rates of pay for registered nurses employed on an intermittent basis (Section 7);
- o clarify that certain VA health care personnel are not constrained by provisions prohibiting employment outside of the VA system (Section 8(a));
- o authorize registered nurses, retired from military service, to be employed by the VA without loss or reduction of their military retired pay (Section 8(b)); and
- o waive parking fees for certain health care personnel (Section 9).

Mr. Chairman, in our opinion, each of these provisions will only serve to assist the Department of Medicine and Surgery in their efforts to employ health care personnel that have been identified as difficult to recruit and retain. Therefore, the DAV has no objection to the favorable consideration of each separate provision.

Section 10 proposes the rescission of proposed VA Regulation -- Code of Federal Regulations (CFR) 17.51(a) (to be effective May 23, 1988) relating to extensions of community nursing home care beyond a period of six (6) months.

The proposed regulatory amendment would provide that any extension beyond six (6) months of community nursing home care, at VA expense, not exceed forty-five (45) days. Such a constraint represents a significant departure from current regulatory authority which provides broad flexibility in decisions to grant an extension based on the individual veteran's particular circumstances.

Mr. Chairman, the question of the VA's policy toward the long-term care needs of disabled veterans is of continuous concern to the DAV. One need only consider recent policy changes regarding the patient mix of long-term care treatment in VA operated nursing homes versus community and state operated nursing home care units, as well as the Administration's lack of

commitment towards new construction of nursing home care beds and the agency's dismal record of bed conversions for long-term care treatment.

Mr. Chairman, the proposed regulatory change simply sends yet another signal that the agency lacks any meaningful policy that will substantially address the long-term care needs of a rapidly aging veteran population.

Quite frankly, with respect to the issue at hand, we are unaware of any factual data that may exist relating to the number of veterans that may be adversely affected by the regulatory change. Therefore, the DAV has no official position on this provision.

However, we are able to support, and indeed suggest, a deferral of implementing the amendments to CFR 17.51(a) until such time as the entire question of the VA's long-term care policy can be studied and evaluated. We feel that this can best be accomplished through the hearing process and request that the Subcommittee give serious consideration to scheduling such a hearing.

Finally, Mr. Chairman, Section 11 of the draft legislation would authorize the Administrator to transfer the title, without compensation or reimbursement to the government, of any medical equipment provided to state medical schools and acquired under the authority of Subchapter I, Chapter 82, Title 38, USC. The DAV has no official position regarding this measure.

That concludes our statement, Mr. Chairman. We wish to thank you and the members of the Subcommittee for allowing us the opportunity to present the views of the DAV on these important health care issues.

Shared Medical Services Between The Air Force and Veterans Administration: Analysis of Concerns Among Providers

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The Veterans Administration and the United States Air Force have directed their Albuquerque, New Mexico, hospitals to locate next to each other and share a variety of medical resources. Service sharing between federal medical agencies is expected to expand in the future due to P.L. 97-174. Data acquired during the planning phase of this project suggest that physicians, nurses, and administrators are concerned about the impact of service sharing on the adequacy of facilities, plans for coordinating services, participation in planning, and impact on clinical practice. These concerns are balanced by a number of advantages, notably financial gains and improved quality of care. The implications of service sharing for other federal medical providers are discussed.

The Veterans Administration (VA) and the United States Air Force (AF) have recently directed their existing Albuquerque hospitals to collocate and share a variety of resources. The Albuquerque Veterans Administration Medical Center (VAMC) is just completing a new hospital incorporating 380 inpatient beds and an outpatient clinic. Because the new VA hospital has sufficient bed capacity to accommodate both VA and AF inpatient care needs, and both organizations have specialty services that the other can share, the Federal Government is anticipating saving tax dollars by jointly using medical facilities to a degree not previously attempted. The AF plans to build new medical and dental outpatient clinics on VA property, conduct its inpatient care in the VA hospital, share various inpatient areas therein, and explore sharing potentials in a wide range of clinical and logistic support functions.

This is the first time that major Department of Defense (DOD) and VA health care facilities have collocated. As such, the precedent-setting effort has been designated a "Joint Demonstration Pilot Project" by executive levels of both agencies. Results of the venture are expected to influence future national policy. Consequently, medical providers in federal installations should be extremely interested in how the joint venture affects clinical practice and the providers at the Albuquerque site. Although reliable answers to this issue can only be confirmed several years hence, at this point

it is appropriate to analyze the concerns of providers in the planning stages of the joint venture. These concerns serve as a barometer of the feasibility of service sharing and joint ventures (these terms will be used interchangeably in this paper) between federal providers.

The purpose of this paper is to analyze the issues confronting medical providers involved in the Albuquerque VA-AF service-sharing project. Specifically, the issues that have surfaced in planning will be identified and analyzed for their applicability to other similar ventures. Now is an opportune time to examine these issues due to the imminent planning of service sharing among federal medical providers. The lessons learned in the Albuquerque experience might facilitate planning in other situations and thereby improve the outcomes for patients and providers.

Background

The idea of a uniquely comprehensive DOD-VA sharing agreement at the Albuquerque VAMC developed over a period of years. The idea of a sharing arrangement authorized under P.L. 97-174¹ was explored mutually by the VA and the USAF in 1984. This idea reached influential people in the Surgeon General's Office in the fall of 1985. Shortly thereafter, a team from the VA Central Office, the Regional Director's Office, the Surgeon General's Office, and the Military Airlift Command visited Albuquerque to discuss plans for sharing options. By January 1986, an agreement had been signed by the USAF Surgeon General and the VA, thus initiating the planning phase of sharing. That phase ended in June 1987, when AF inpatient and emergency room activities moved into the VA facility. Air Force-scheduled outpatient activities continued at the old facility two miles away. Split AF operations will end in 1989 when new AF outpatient facilities are constructed adjacent to the VA hospital.

Economic and political changes taking place in the public sector provided the impetus for development of the VA-AF relationship in Albuquerque. The VA hospital had been designed in 1975, and many of the premises underlying its planning were no longer valid when construction was finished in 1986. The health care environment was witnessing an increasing emphasis on ambulatory care and a decreasing length of inpatient stay. The impact of these trends on the VAMC would likely have resulted in underutilized bed capacity. At this same time, a moratorium on construction of military hospitals with less than 50 beds was imposed by the General Accounting Office. Kirtland Air Force Base administrators were faced with a deteriorating facility, and no means of constructing a new one or renovating the old one.

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A joint venture offered considerable promise for filling both VA and AF needs under these circumstances.

The goals of the sharing project are to improve services for both VA and AF patients, efficiently utilize federal services, and contain costs in an era of fiscal constraint. Also implicit in the arrangement is the mutual desire to make each health system more cost effective, improve their images, and foster their survival. From a provider perspective, these are all laudable goals.^{2,3} However, there are often significant discrepancies between well intentioned ideas and actual practice. What problems can federal medical providers anticipate when planning a sharing arrangement?

The implications of the VA-AF project are also relevant to medical providers in non-federal institutions. VA hospitals possess many of the same characteristics and cost problems⁴ as those of system-affiliated hospitals.^{5,6} Unfortunately, much of the research on joint ventures and multihospital systems has focused on classifications or taxonomy⁷⁻¹⁰ rather than the implications of multi-institutional alliances for clinical practice. The research has investigated the extent to which system hospitals differ from non-system hospitals on broad structural and ownership indicators.^{11,12} There is growing concern that health services research has overlooked the important impact of multi-institutional alliances on patient care.^{13,14}

Methodological Approach

Since there have been no prior published studies of joint ventures between AF and VA medical branches, this study is viewed as a pilot project as far as the methodological approach is concerned. It was necessary to adopt a case study approach that defined and documented critical events as they occurred and that measured reactions of participants in the joint venture as the sharing arrangement crystallized.

Methodologically, it is vital to evaluate how providers and other constituents accommodate the joint venture from the inception of planning through actual implementation. However, waiting until this project is completely implemented to report significant lessons learned about shared services would not provide timely information to other federal installations currently contemplating a sharing arrangement. Therefore, this report concentrates on the planning of the AF and VA for the joint venture. Subsequent reports on how provider attitudes changed over time will be forthcoming as the joint venture progresses. Meanwhile, there is a wealth of information that is useful to federal medical providers who are planning sharing ventures.

Procedures and Measures

Data for this report have been collected through indepth structured personal interviews, archival data, meeting observations, and survey questionnaires. In establishing baseline attitudes of providers (i.e., physicians and nurses) and administrators toward the joint venture, a survey questionnaire was conducted during the planning stages of this project. Simultaneously, structured interviews were undertaken. Senior AF and VA administrators provided information on strategic and historic events, as well as information on their attitudes toward the joint venture. The AF

and VA physicians and nurses provided similar attitudinal information in the interviews which helped to interpret comments on the survey questionnaires.

Proper research methodology was followed throughout the construction, administration, and analysis of the survey questionnaires and structured personal interviews. (Copies of the questionnaires or structured interviews are available on request from the senior author.) The research team also participated in periodic planning meetings held by the VA and AF. These meetings proved to be a valuable source of impressionistic and archival data on the joint venture. Through these observations, the data from the questionnaires and interviews were interpreted with greater clarity.

Sample

For the purposes of this study, the sample of medical providers was broadly defined to include VA and AF physicians (and physician extenders), nurses, and health services administrators. As in most clinical settings, the medical providers (i.e., physicians and nurses) depend on support and administrative services (i.e., health services administrators) to effectively deliver patient care. Data were acquired from the following:

- Survey questionnaires completed by VA ($n = 70$) and AF ($n = 21$) physicians
- Survey questionnaires completed by VA ($n = 118$) and AF ($n = 29$) nurses
- Survey questionnaires completed by VA ($n = 49$) and AF ($n = 23$) health services administrative staff
- Content analysis of meetings for VA-AF joint study groups ($n = 30$) assigned to plan the service sharing
- Attendance at senior level VA-AF planning meetings
- Review of project correspondence in files
- Interviews with senior administrators in the VA ($n = 3$) and the AF ($n = 3$)

These sources provided a rich database on the concerns of providers who are facing a shared services arrangement.

The following response rates were attained for the survey questionnaires:

Respondent	Number In Sample Population	Number Responding	Response Rate (%)
VA Physicians	96	68	70.8
AF Physicians	34	21	61.8
VA Nurses	225	121	53.8
AF Nurses	37	29	78.4
VA Administrators	83	48	57.8
AF Administrators	28	22	78.6

As these statistics suggest, there was exceptional cooperation in the survey questionnaire portion of this study.

Analysis

An analytical framework incorporating six major dimensions of service sharing impact was used:

1. Expressed concerns surrounding shared services
2. Attitudes toward shared services

3. Perceived important advantages from shared services
4. Attitudes toward the planning process
5. Perceived impact of service sharing on clinical practice
6. Perceived implications for patient care and working conditions

These six dimensions guided the development of the survey questionnaires and structured interviews, as well as the subsequent data analysis. This framework could be replicated in evaluating and managing concerns among providers in other federal installations. In this manner it may be possible to reduce stress associated with and negative reactions to the merger.

Descriptive statistics were the main analytical tests used in this study to convey the overall concerns of the providers with the mergers. When appropriate, additional statistical tests using regressions and *t* tests to compare the responses by groups of providers (e.g., AF physicians vs. VA physicians) were undertaken to confirm the conclusions from the descriptive statistics.

Results

Concerns about Service Sharing

Table 1 presents the most serious concerns of VA and AF physicians, nurses, and administrators about service sharing. The primary concern listed by the physicians is the inadequate capacity of the facility. There are problems in space for physician offices as well as the space for examination rooms, procedure areas, or other clinical space. This re-

sponse may seem paradoxical because the VAMC hospital is projected to have excess capacity. There are many plausible explanations for this finding. However, the survey data suggest that physicians are reacting to the loss of expansionary space and to sharing space and equipment with other practitioners over whom they have little control.

Both VA and AF physicians perceive that there will be problems in coordinating with the other service branch. Coordination is the second most serious concern among the physicians. The coordination issue is listed as the highest concern among the VA and AF nurses. The VA and AF administrators agree with the physicians and nurses. The providers are concerned about whether there will be sufficient space for them to perform their services, and they are concerned about how two unique federal agencies are going to cooperate in a single facility.

The concerns noted above are not unjustified, nor are they unanticipated. The lesson for shared medical services arrangements is to remain sensitive to and resolve the concerns of providers. To prevent these concerns from becoming actual problems, it would be necessary to: 1) incorporate providers in the design stage, and 2) prepare a plan in advance for how shared service operations will be undertaken.

Other than minor discrepancies in the rank order of the respondents' concerns, there is nearly unanimous agreement about what concerns confront medical providers. The homogeneous nature of the concerns may be beneficial in devising and implementing solutions to minimize these concerns. It should be remembered that the respondents are describing concerns associated with planning. Hence, there is a need to create plans which prevent these concerns from becoming reality.

TABLE 1
CONCERNS ABOUT SHARED SERVICES

Respondent	Concerns Ranked In Order Of Importance
VA Physicians	1. Inadequate capacity of the facility 2. Coordination with AF 3. Negative view of sharing 4. Negative influence on quality of care
AF Physicians	1. Inadequate capacity of the facility 2. Coordination with VA 3. Suspicion of sharing intent 4. Negative influence on quality of care
VA Nurses	1. Coordination with AF 2. Inadequate capacity of the facility 3. Suspicion of sharing intent 4. Negative view of sharing
AF Nurses	1. Coordination with VA 2. Negative view of sharing 3. Inadequate capacity of the facility 4. Suspicion of sharing intent
VA Administrators	1. Coordination with AF 2. Inadequate capacity of the facility 3. Suspicion of sharing intent 4. Negative view of sharing
AF Administrators	1. Coordination with VA 2. Inadequate capacity of the facility 3. Negative influence on quality of care 4. Suspicion of sharing intent

Attitudes Toward Shared Services

Table 2 presents additional data related to the service sharing concerns. The providers were asked to indicate their attitudes toward shared services. The results in Table 2 suggest that the service sharing is not embraced enthusiastically. In terms of their personal feelings about the sharing venture, as a group the VA physicians, nurses, and administrators are much more positive than their AF counterparts. The AF physicians and nurses are fairly neutral about the sharing venture. The VA physicians and administrators are more enthusiastic than other respondents about the venture. Of all providers, the nurses have the most negative attitudes. The administrators are most positive.

For the most part, these trends are replicated in the remaining questions presented to the respondents. VA physicians, nurses, and administrators are much more positive than their AF counterparts in describing how patients and people with whom they work view the sharing venture. However, only the VA physicians and AF administrators are positive about how the sharing venture will affect patients or staff. The AF physicians and nurses, and the VA nurses and administrators are neutral to negative in their attitudes toward how the joint venture will affect patients and staff. In sum, the respondents are much more positive about their own feelings about the merger than about the perceived impact of the merger on patients or staff.

TABLE 2
PROVIDER ATTITUDES TOWARD SHARED SERVICES

Respondent	How do you describe your feelings about the sharing venture?			How do people with whom you work describe the sharing venture?			What is your impression of how patients view the sharing venture?		
	n	Mean	SD	n	Mean	SD	n	Mean	SD
VA Physicians	70	4.26*	0.88	68	3.80	0.90	55	3.43	1.06
AF Physicians	31	3.38	1.02	21	3.05	1.02	18	2.94	0.80
VA Nurses	114	3.70	1.16	106	2.97	1.02	87	3.04	1.02
AF Nurses	29	3.03	1.24	28	2.45	1.18	23	2.52	0.99
VA Administrators	47	4.23	1.00	46	3.56	0.95	37	2.62	0.82
AF Administrators	22	3.81	1.00	21	3.23	0.94	16	3.50	0.89

* Responses to a five-interval scale (1 = Negative; 5 = Positive).

Advantages of Shared Services

The providers identified a number of advantages to service sharing, shown in ranked order in Table 3. The VA physicians and nurses and VA-AF administrators indicate that the most important advantage of service sharing involves financial or efficiency advantages. The AF physicians and nurses list improved or increased resources as the most important advantage of service sharing, while the AF administrators list increased resources as the second most important advantage. This difference between the VA and AF can be explained by the fact that the VAMC is approximately eight times larger than the AF hospital. Hence, AF physicians and nurses will have access to more resources. The VA providers who are accustomed to this level of re-

source intensity view the new facility as an improvement over their old hospital. They should be able to provide care more efficiently with new equipment and facilities.

Although there is considerable variability in the rank ordering by VA and AF providers, there is remarkable consistency in the types of advantages produced by service sharing. The physicians, nurses, and administrators indicated that the sharing arrangement would facilitate quality of care and enrich the staff. Other service sharing arrangements should consider these advantages when attempting to derive commitment to a joint venture.

Attitudes Toward Planning

Table 4 indicates the providers' perceptions of the extent to which planning steps are being communicated to them and the extent to which they are actively involved in the planning process. The AF physicians and the VA administrators are the only respondents who agree that they are adequately involved in the planning process and to whom planning issues are being effectively communicated. The remaining respondents disagree that they are receiving enough information about planning steps or issues, and they disagree that they are adequately involved in the planning process. On the whole, the providers are concerned about their involvement in and communication from the planning process.

As Table 4 suggests, the VA nurses strongly disagree that planning steps and issues are being communicated to them,

TABLE 3
IMPORTANT ADVANTAGES OF SHARED SERVICES

Respondent	Advantages Ranked In Order Of Importance
VA Physicians	1. Financial/efficiency advantages 2. Improved quality of care 3. Improved/increased resources 4. Staff enrichment
AF Physicians	1. Improved/increased resources 2. Financial/efficiency advantages 3. Improved quality of care 4. Staff enrichment
VA Nurses	1. Financial/efficiency advantages 2. Improved/increased resources 3. Improved quality of care 4. Staff enrichment
AF Nurses	1. Improved/increased resources 2. Improved quality of care 3. Financial/efficiency advantages 4. Staff enrichment
VA Administrators	1. Financial/efficiency advantages 2. Improved quality of care 3. Staff enrichment 4. Improved/increased resources
AF Administrators	1. Financial/efficiency advantages 2. Improved/increased resources 3. Improved quality of care 4. Staff enrichment

TABLE 4
PROVIDER ATTITUDES TOWARD THE PLANNING PROCESS

Respondent	Planning steps and issues are being communicated to me			We are adequately involved in the planning process		
	n	Mean	SD	n	Mean	SD
VA Physicians	69	3.31*	1.41	66	4.19	1.21
AF Physicians	21	2.66	1.31	20	2.55	1.39
VA Nurses	115	4.10	1.10	116	4.25	1.05
AF Nurses	27	3.44	1.33	28	3.46	1.37
VA Administrators	48	2.60	1.39	48	2.64	1.32
AF Administrators	23	3.26	1.09	23	3.08	1.08

* Responses to a five-interval scale (1 = Strongly agree; 5 = Strongly disagree).

or that they are adequately involved in the planning process which may explain their more negative attitudes toward sharing in Table 2. The VA physicians and AF nurses express less disagreement than the VA nurses, but it is apparent that they perceive that they are being left out of the planning process to some degree. The continuum from AF physician involvement to VA nurse alienation may be a function of their numbers; communicating with 225 nurses spread across many shifts and locations is more difficult than involving only 34 physicians.

Service Sharing and Clinical Practice

Table 5 provides an overview of the providers' perceptions of the impact of shared services on clinical practice. These data are very important in managing service sharing to make certain that clinical practice is not hampered. It should be remembered that these responses represent perceived effects. Actual impact of service sharing on clinical practice will be measured in subsequent studies. Nonetheless, Table 5 provides a map to planners. It suggests where administrative attention should be focused to minimize the adverse effects of service sharing on medical care delivery.

The VA physicians and VA-AF administrators consistently predict that service sharing will have a beneficial impact on clinical practice (except for accessibility to the operating room and clinical space). For the most part, the AF physicians perceive that service sharing will have a positive effect on clinical practice. However, the AF physicians are negative about the impact on almost half of the clinical practice dimensions which may relate less to sharing than to concerns about their temporary geographic separation of inpatient and outpatient activities. The AF and VA nurses also

perceive a negative impact on clinical practice. Variability in responses makes it difficult to define a specific trend in the data. Nonetheless, the AF physicians and nurses, and VA nurses perceive that the sharing arrangement will negatively affect their clinical practice.

For the most part, the providers perceive that the sharing arrangement will have a positive effect on the major objectives of the merger:

- quality of patient care
- cost of care (with noted exceptions)
- efficient use of VA and AF services

Furthermore, sharing will help promote specialty consultation. The VA and AF physicians believe that the service sharing will improve their ability to manage patient care, but the VA and AF nurses disagree with this prediction.

Patient Care and Working Conditions

Table 6 provides an overview of how the providers believe the sharing arrangement will affect patients and staff. The AF physicians, nurses, and administrators generally are split over the impact on patients and staff. On the one hand, they express that the venture will improve conditions for AF staff and patients, but, on the other hand, they also perceive that conditions will worsen for AF staff and patients compared to VA staff and patients. According to the AF providers, AF staff and patients will be most negatively affected by the sharing arrangement.

The VA physicians perceive that conditions will improve most for AF patients and staff. Yet, they also perceive worse conditions for VA patients and staff compared to AF patients and staff. The VA nurses and VA administrators replicate this pattern. They generally believe that AF patients and

TABLE 5
IMPACT OF SHARING ON CLINICAL PRACTICE

Practice Issue	VA Physicians			AF Physicians			VA Nurses			AF Nurses			VA Administrators			AF Administrators		
	n	Mean	SD	n	Mean	SD	n	Mean	SD	n	Mean	SD	n	Mean	SD	n	Mean	SD
1. Quality of Patient Care	64	3.61*	1.00	18	3.44	0.78	91	3.28	0.89	26	3.23	1.21	44	3.61	0.92	17	3.70	0.83
2. Cost of Care	66	3.92	1.05	19	2.68	1.06	92	3.61	1.02	24	2.63	1.25	42	3.83	1.03	18	3.22	1.35
3. Efficient Use of VA and AF Services	66	3.92	1.05	20	3.00	1.12	91	3.60	1.05	24	3.21	1.25	44	4.06	1.02	17	3.76	1.20
4. Interaction Between VA and AF	65	3.78	1.09	19	3.47	0.77	91	3.38	1.05	24	3.00	1.32	45	3.64	0.95	16	3.56	0.72
5. Specialty Consultation	66	3.54	1.08	20	3.75	1.07	94	3.28	0.93	25	2.85	1.19	NA†			NA		
6. Ability to Manage Patient Care	60	3.20	0.86	19	3.05	0.91	91	2.93	0.92	27	2.86	1.20	NA			NA		
7. Interaction With Medical/Nursing Staff	65	3.78	1.09	19	3.47	0.77	91	3.38	1.05	24	3.00	1.32	NA			NA		
8. X-ray Service	66	3.04	1.15	20	2.66	1.27	91	2.92	1.04	23	3.48	1.30	NA			NA		
9. Lab Service	64	3.00	1.13	19	2.58	1.22	89	2.85	1.10	24	3.54	1.25	NA			NA		
10. Workload	65	3.25	1.21	19	2.59	0.96	94	2.71	0.94	25	2.60	0.91	43	2.80	1.31	18	2.77	1.00
11. Accessibility to OR or Clinical Space	63	2.60	1.04	19	2.21	1.13	NA			NA			NA			NA		

* Responses to a five-interval scale (1 = Negative; 5 = Positive).

† NA = not applicable.

TABLE 2
PERCEIVED IMPACT OF SERVICE SHARING ON PATIENT CARE AND WORKING CONDITIONS

Conditions for	Percent of VA Physicians Expecting				Percent of AF Physicians Expecting			
	Improve*	No Chg†	Worse	No Response	Improve	No Chg	Worse	No Response
VA Patients	15	96	14	9	19	48	4	29
AF Patients	67	13	3	17	43	19	23	14
VA Staff	29	47	18	9	29	38	4	29
AF Staff	58	18	6	20	38	10	33	19

Conditions for	Percent of VA Nurses Expecting				Percent of AF Nurses Expecting			
	Improve	No Chg	Worse	No Response	Improve	No Chg	Worse	No Response
VA Patients	15	48	12	25	24	41	14	21
AF Patients	30	28	3	38	45	14	24	17
VA Staff	18	35	20	27	17	48	10	24
AF Staff	19	30	11	40	48	10	24	17

Conditions for	Percent of VA Administrators Expecting				Percent of AF Administrators Expecting			
	Improve	No Chg	Worse	No Response	Improve	No Chg	Worse	No Response
VA Patients	23	54	6	17	9	39	4	48
AF Patients	60	12	2	25	35	17	13	35
VA Staff	25	45	19	10	9	3	9	52
AF Staff	35	27	6	31	13	17	30	39

* Improvement

† No Change

staff will benefit more than VA patients and staff. This contrasts with the AF providers who perceive some distinct benefits for AF patients and staff, yet who also perceive that AF patients and staff will be negatively affected by shared services. Some AF negativism may relate to the prospects of split inpatient and outpatient operations.

Implications For Service Sharing

What are the implications of the concerns expressed by VA and AF providers in the Albuquerque joint venture for service sharing? As this study of the planning stages of the VA-AF sharing project has indicated, there are a number of concerns by providers that should be acknowledged when proposing a joint venture. These concerns include:

1. Adequacy of the facilities to support clinical services without hampering providers' ability to deliver the highest quality of care (cf. Table 1).
2. A plan for coordinating service sharing that is equitable to each partner and that specifies an acceptable concept of operations (cf. Table 1 and Table 6).
3. Acceptability of the concept by providers and by patients (cf. Table 2).
4. Adequate involvement in and periodic information about the planning process (cf. Table 4).
5. Potential of the sharing arrangement to adversely affect specific elements of medical practice (cf. Table 5).

These concerns are readily solvable if a planning system is established that has mutual representation, equal authority, equivalent levels of investment (i.e., in staff and support resources), and a commitment to the success of the project.^{15,16}

The concerns noted in this study are counterbalanced by

a powerful set of advantages that can be derived from service sharing. Among the most important advantages foreseen by the providers were financial and efficiency advantages, staff enrichment, and improved or increased resources (cf. Table 3). In an era of constrained public budgets, these advantages are significant for federal sharing projects. However, it is also the belief of the providers that quality of care will be improved in a sharing project (cf. Table 3). Access to a more diverse resource base, including specialty care, diagnostic and treatment equipment, consultation, and referral are all gains that can improve the quality of care delivered to beneficiaries.

At this point in the Albuquerque VA-AF project, there is emphasis on implementing shared services to avoid the concerns and maximize the advantages noted above. The VA and AF administrative staffs have already confronted and attempted to reconcile the concerns of providers during the planning process. Whether the interventions, agreements, and resolutions to predicted problems are satisfactorily implemented will be seen over the next few years. For the moment, it is valuable to identify providers' concerns in the Albuquerque joint venture in order that they can be effectively recognized and addressed when planning other federal shared medical services projects. Coupled with an emphasis on the advantages of service sharing, it may be feasible in other locations to orchestrate joint ventures that efficiently utilize federal resources while contributing to improved quality of patient care.

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